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Accessing the Right to Choose: Factors Predicting the Enactment of State-Level Abortion Clinic Access Laws

Hannah Gourdie

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Accessing the Right to Choose: Factors Predicting the Enactment of State-Level Abortion Clinic
Access Laws

A thesis submitted in partial fulfillment of the requirement
for the degree of Bachelor of Arts in Department of Government from
The College of William and Mary

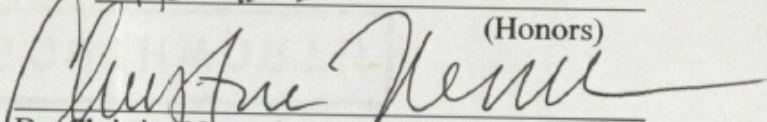
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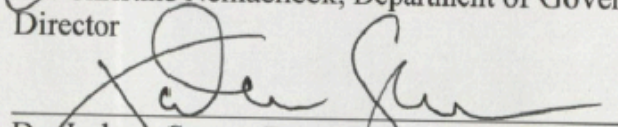
Hannah Gourdie

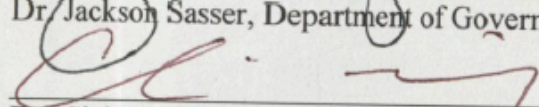
Accepted for

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Chapter 1: Introduction

During the 1980s and early 1990s, reproductive health clinics experienced a spike in targeted violence and harassment. All states experienced some degree of violence, protests, and harassment, which ranged from legal demonstrations, to massive protracted blockades of clinics, to clinic bombings and arsons, and to the murder and kidnapping of abortion providers (Baird-Windle and Bader 2001; Blanchard and Prewitt 1993; Doan 2007; Mason 2004; Munson 2008).

In the face of this elevated anti-abortion activity, a subset of states passed laws specifically aimed at protecting patients' access to clinics and clinic employees' safety.¹ Currently, 16 states and DC have clinic access laws prohibiting damage to clinic property, harassment of those going into clinics, obstruction of clinic entrances, and/or online harassment of clinic employees. Further, four of these states—Massachusetts, New Hampshire, Colorado, and Montana—have implemented laws creating “buffer zones” around abortion clinics. Massachusetts's and New Hampshire's laws create “fixed” buffer zones, or demarcated areas around all or parts of a clinic where only patients, volunteers, and clinic employees can enter, thereby preventing protestors from passing through these zones. Colorado's and Montana's laws also create “floating” buffer zones or “bubble zones,” meaning that they stop protestors from coming within a certain distance of individual patients, volunteers, and clinic employees. Buffer zone laws are the most contentious of the various kinds of clinic access laws. Both Colorado's and Massachusetts' laws have been challenged by antiabortion protestors in cases that reached the Supreme Court (*Hill v. Colorado* 2000, 530 US 703; *McCullen v. Coakley* 2014, 573 US __)

¹ I use the terms “anti-abortion” and “anti-abortion rights” here to refer to the stance that is commonly called “pro-life.” I recognize that language can be indicative of ideology, and I chose this language carefully. I use the terms “anti-abortion” and “anti-abortion rights” rather than “pro-life” to reflect the end goal of the abortion rights movement: to render abortion illegal and/or completely inaccessible. Although this terminology is somewhat uncommon, several scholars who have examined abortion policy, clinic access laws, and clinic violence and harassment use these terms (Bartholomew 2012; Freilich and Pridemore 2007; Kreitzer 2015b; Medoff 2012; Medoff and Dennis 2011; Wilson 2013)

on the grounds that they violated protesters' First Amendment right to free speech.

This paper explores the factors that explain why states enact these varying kinds of clinic access laws or fail to do so even if they have experienced episodes of clinic violence and harassment. According to literature on the subject, abortion policy is influenced by five main factors: public abortion attitudes, anti-abortion interest groups, state political ideology, and partisan control of the state legislature and governor's office (Cohen and Barrilleaux, 1993; Medoff and Dennis, 2011). Researchers have used these variables to study the influence of states' political cultures on the restrictiveness of their abortion laws (Cook, Jelen, and Wilcox, 1993), county-level voting patterns on state ballot abortion initiatives (Roh and Haider-Markel, 2003), and the enactment of targeted regulations of abortion providers ("TRAP" laws; Medoff and Dennis, 2011). The literature has also given some attention to the influence of female state legislators on abortion laws (Berkman and O'Connor 1993; Medoff 2002; Medoff 2012). In the clinic access law literature, scholars have investigated how a state's tolerance for gender-based violence influences levels of anti-abortion harassment and violence targeted at clinics. This literature has also studied the effects of access laws themselves on anti-abortion violence and harassment (Bartholomew 2012; Freilich and Pridemore 2007; Jacobsen and Royer 2011). However, there has not yet been a study that empirically evaluates the specific predictors of the enactment of clinic access laws. Thus, to fill in this gap in the state abortion policy literature, this paper aims to answer the following question: what political, social, and institutional conditions explain why states enact clinic access laws?

This paper will also analyze how states choose between the two types of clinic access laws: (1) those containing provisions prohibiting damage to and obstruction of clinics and/or harassment of patients and employees, and (2) those containing buffer zone provisions. Unlike

the first category of laws, buffer zone statutes have been legally challenged on the grounds that they impermissibly infringe on the speech of anti-abortion protestors. However, supporters of these laws argue that they safeguard individuals' right to privacy. This constitutional right has been found in the First, Third, Fourth, Fifth, Ninth, and Fourteenth Amendments, and the Supreme Court has held that it protects a woman's ability to decide whether to terminate a pregnancy (*Roe v. Wade* 410 U.S. 113, 1973). In this way, buffer zone laws create tension between two fundamental civil liberties, and their contentious nature engenders the following questions: to what extent does a state's historical approach to free speech influence the likelihood that it will enact a buffer zone law?

Finally, abortion policy has long been regarded as a "clash of absolutes" (Tribe 1984). Laden with discourses about sin and (im)morality, abortion politics appears to have polarized into pro-choice and anti-abortion camps. Consequently, numerous scholars classify abortion policies as "morality policies" (Mooney 2001). They find that the restrictiveness of state-level abortion policy is driven by mass-level pressures, such as public abortion attitudes and mass political ideology (Camobreco and Barnello 2008; Norrander and Wilcox 1999). Yet, focusing on a specific set or type of abortion policies blurs this picture. Abortion policies that are complex, symbolic, and less salient do not necessarily display such characteristics. They are better predicted by elite-level and institutional factors such as partisan government control, and consequently, are better categorized as redistributive policies (Kreitzer 2015a; Kreitzer 2015b; Medoff 2012; Medoff and Dennis 2011). Drawing inspiration from Medoff (2012) and Medoff and Dennis (2011), this study seeks to understand whether clinic access laws correspond best with a morality or redistributive framework of policymaking.

Chapter 2 of this thesis reviews the relevant literature on clinic access laws and the determinants of state-level abortion policies. It also includes a brief overview clinic violence and harassment. Chapter 3 covers the specific research questions, theoretical frameworks, and hypotheses this thesis tests as well as the data collection and analysis methodologies used to do so. Chapter 4 outlines the results of and discusses these analyses. The analyses demonstrate that the percent of female legislators in a state legislature and the presence of the federal clinic access law significantly predict clinic access law enactment. Further, they suggest that a state's past approach to free speech policy does not impact the likelihood that it will enact a clinic access law. Finally, they show that clinic access laws are redistributive policies, not morality policies. Chapter 5 includes concluding remarks.

Chapter 2: Literature Review

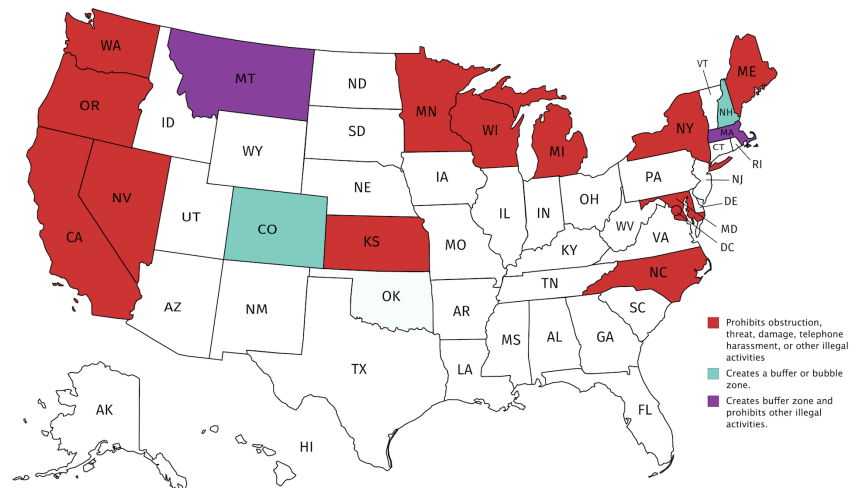
This literature review will cover the content and enactment of clinic access laws at both the state and the national levels. Next, it will provide an overview of the determinants of state abortion policy that past research has identified (public abortion attitudes, anti-abortion interest group strength, state mass political ideology, partisan control of the state government, and abortion rates) and the mechanisms through which they shape a state's abortion-related laws. This study also addresses several other possible determinants of clinic access law enactment, including clinic violence and harassment, the percent of female legislators in a state, and state approaches to gender-based violence.

Clinic Access Laws: Content and Enactment

Since the 1980s, the federal government, states, and municipalities have passed laws and ordinances aimed at deterring anti-abortion clinic violence and harassment. In 1985, Wisconsin was the first state to enact a measure to counter anti-abortion activities at reproductive health

clinics. The Guttmacher Institute (2018a) notes that 16 states and DC currently have clinic access laws. These laws perform a variety of functions, including prohibiting obstruction of abortion clinic entrances, damage to clinics, and harassment of clinic employees, volunteers, and patients (Guttmacher Institute 2018a). Four states—New Hampshire, Montana, Massachusetts, and Colorado—have enacted buffer and bubble zone laws that establish no-protest zones around clinics in the state (Guttmacher Institute 2018a). Generally, clinic access laws impose criminal and civil penalties for clinic violence and harassment that are heavier than those that state and municipal laws dealing with violence, property damage, noise limits and the like impose (Bartholomew 2012, 47). Figure 1 provides an overview of the states with buffer zone laws.

Figure 1. Geographic distribution of clinic access laws color-coded by type.²



Two of the four buffer zone laws in existence were challenged in the Supreme Court on the grounds that they infringed upon anti-abortion demonstrators' First Amendment right to free speech. In *Hill v. Colorado*, the Court upheld the Colorado “bubble zone” statute that prohibits coming within eight feet of another person to protest or engage in “sidewalk counseling” within

² The information for this map comes from The Guttmacher Institute’s webpage, “Protecting Access to Clinics” (2018). The map was generated using Mapchart (Mapchart.net).

a 100-foot radius of a clinic. Fourteen years later in *McCullen v. Coakley*, the Court struck down the 2000 Massachusetts buffer zone law prohibiting all picketing, demonstrations, and sidewalk counseling within 35 feet of the state's clinics. The Court found that the Massachusetts statute was not narrowly tailored enough to pass constitutional muster. The law was amended in 2014 to require those deemed to be obstructing a building's entrance(s) to remain at least 25 feet away from the clinic until the end of the clinic workday (Gogniat 2015, 247).

In response to rising levels of clinic-based violence and harassment during the 1980s and 1990s, Congress passed the Freedom of Access to Clinic Entrances Act ("FACE") in May 1994 (18 U.S. Code § 248). The law bans obstruction of clinic entrances and damage to clinic property, as well as injury to, intimidation of, and interference with those seeking reproductive health services.³ FACE's initial impact on levels of clinic violence and the degree of protection it afforded to clinics was "limited" (Cohen and Connon 2015, 209). The statute effectively reduced clinic blockades and invasions, but other forms of clinic violence and harassment continued to rise (Cohen and Connon 2015, 209). Moreover, abortion providers have commented that the law's standard for determining when anti-abortion activity is "threatening" is too exacting, making it difficult to seek legal protection under the law (Cohen and Cannon 2015, 208-11). In response to these shortcomings, reproductive health care providers pushed for municipal ordinances and state-level laws that would require local and state police to regulate more minor anti-abortion activities, like vandalism and harassment, at clinics (Cohen and Cannon 2015, 211; 214-6). Subsequently, cities and states continued to enact their own clinic access laws to manage

³ The law also prohibits obstructing, injuring, intimidating, or interfering with those exercising their religious freedom at a place of religious worship as well as damage to a place of religious worship (18 U.S. Code § 248 2014).

other forms of clinic violence and harassment and allow for legal remedies through state court systems (Cohen and Cannon 2015, 211).

Although they facilitate abortion access, clinic access laws are not framed as typical pro-abortion rights policies. During the legislative process, political elites often portray clinic access laws as a way to ensure public safety in the face of clinic violence and harassment. This strategic framing allows these laws to garner bipartisan support as well as acceptance from anti-abortion activists who engage in nonviolent means of protest, like sidewalk counseling and picketing (Wilson 2013, 122-6). Thus, these laws are particularly complex since they touch on multiple policy areas, including speech rights, abortion and privacy rights, and public safety (Kreitzer 2015a, 68).

Determinants of State-Level Abortion Policy

Past scholarship has identified five main influences on state-level abortion policy: public abortion attitudes, abortion-focused interest groups, state mass political ideology, partisan control of the state legislature and governor's office, and abortion rates (Cohen and Barrilleaux 1993; Medoff, Dennis, and Stephens 2011; Medoff 2012). Research has also assessed the influence of female state legislators on abortion policy (Berkman and O'Connor 1993; Norrander and Manzano 2011; Medoff 2002; Swers 1998). Further, in the clinic access law literature, scholars have studied the specific connections between access laws, clinic violence and harassment, and states' approaches to gender-based violence. I now turn to a discussion of these variables, their effects on state-level abortion policy in general, and their possible relationships to clinic access laws.

Public abortion attitudes

While opposition to legal abortion has declined slightly since *Roe*, the public's views on

the legality of abortion have remained mostly stable for the last forty years. Medoff, Dennis, and Stephens (2011) remark that nearly all Americans are at least vaguely familiar with abortion policy and that most Americans have formed an opinion on its legality and morality because it requires little technical knowledge to do so (325-6). As a result, general opinions on abortion tend to be stable, rigid, and dichotomous (Rosenberg 2015, 245; Saad 2002). In fact, Supreme Court cases on abortion policy have only negligibly affected Americans' opinions on abortion due in part to the strength of these views.⁴ Further, Norrander and Wilcox (1999) note that abortion policy is highly salient and is often framed in terms of sin and morality, driving the polarization of public abortion attitudes into dichotomous pro-choice and anti-abortion camps. As a result of these characteristics, abortion provokes large proportions of the US population to become politically active around the subject, placing pressure on political elites to generate abortion policies that reflect the attitudes of their constituents (Norrander and Wilcox 1999, 708). This trend has strengthened since *Roe*. Camobreco and Barnello (2008) show that public abortion attitudes have become a more significant influence on abortion restrictions than elite abortion attitudes. Notably, Medoff, Dennis, and Stephens (2011) find that state-level abortion policies typically track with the global public abortion attitudes in a state, or the public's beliefs about the general legality, morality, and constitutionality of abortion. In contrast, public attitudes about specific abortion regulations normally do not influence the restrictiveness of state-level abortion policies. State residents are often unaware of the specific abortion regulations in their state, and lawmakers encounter great difficulty when attempting to glean their constituents' specific abortion attitudes (Medoff, Dennis, and Stephens 2011, 247; Kreitzer 2015a, 22).

⁴ The Supreme Court generally does not have a major impact on most deeply held beliefs. Persily et al. (as cited in Rosenberg 2015) found that Supreme Court decisions on "desegregation, rights of the accused, school prayer, abortion, gay rights, and the war on terror and civil liberties" had few effects on public opinion on these issues (244).

Abortion-related interest groups

Single-issue interest groups influence the policy positions of both legislators and citizens (Roh and Haider-Markel 2003, 17; Medoff, Dennis, and Stephens 2011, 958). These groups often endorse positions on abortion that are more polarized and less nuanced than those of the general population (Roh and Haider-Markel 2003, 21-2; Norrander and Wilcox 1999, 707). Interest groups typically represent the most politically engaged voters and activists “who can give, or withhold, political contributions and resources for political campaigns” (Medoff and Dennis 2011, 958). These conditions tend to spur legislators to vote in line with the views of the strongest interest groups in their states. For example, Medoff (2002) demonstrates that there is a negative relationship between the proportion of a state’s citizens who are members of the National Abortion Rights Action League (NARAL)—the oldest and largest pro-choice advocacy and lobbying group in the US—and the number of abortion restrictions that the state’s government enacts (487).

Anti-abortion groups are often more reluctant than pro-choice groups to turn over state membership data to researchers upon request (Medoff 2002, 485). Consequently, past literature has measured the strength of anti-abortion interest groups using the percent or proportion of a state’s population that is Catholic and/or Evangelical Protestant (Medoff, Dennis, and Stephens 2011, 958; Medoff 2012, 248). Meyer and Staggenborg (1996) demonstrate that the Roman Catholic Church’s long-standing anti-abortion position galvanizes a large majority of its members to mobilize against the liberalization of abortion access (1643). Additionally, the Church encourages anti-abortion direct action, such as clinic protests, by connecting abortion to broader arguments about Catholic lifestyles and values, such as the right to life. This tactic appeals to a broad swath of its members because it frames abortion in moral rather than political

or economic terms (Norrander and Wilcox 1999). Similarly, Evangelical Protestant preachers, televangelists, and congregation members foster anti-abortion attitudes through their religious social networks and engage in anti-abortion political and direct action (Wilcox 1989, 63-4). The emergence of the conservative Religious Right during the 1980s and the rise of Operation Rescue—a national anti-abortion activist group that protested and blockaded clinics throughout the late 1980s and the early 1990s—in 1987 sparked the influx of Evangelical Protestants into the anti-abortion movement (Munson 2008, 87-9).

The influence of Catholics and Evangelical Protestants on state-level abortion policy is mixed. Medoff (2012) and Medoff and Dennis (2011) find that the percent of a state's population involved in Evangelical Christian denominations significantly increases likelihood that a state will enact a TRAP law, but the percent of Roman Catholics does not.⁵ Still, the percent of Roman Catholics in a state's population is positively associated with the restrictiveness of the state's abortion policy (Medoff 2002, 481). These variations in religious influence may result from the diversity in the abortion attitudes of Evangelical Protestants and Catholics. While members of both religious groups overwhelmingly endorse anti-abortion attitudes, Catholics were still three times likelier than Evangelicals to endorse pro-choice attitudes during the 1990s (Guth et al., 1993, 70). Currently, 48% of Catholics support legal abortion, and 47% oppose it. Evangelicals are more unified in their abortion preferences: 63% oppose legal abortion, while only 33% support it (Masci 2018). Nevertheless, both of these studies illustrate that the percent of Catholics and/or Evangelical Protestants in a state's population can independently influence the state's abortion laws. In other words, the effects of anti-abortion interest groups on legislative

⁵ TRAP laws place stringent regulations on reproductive health care clinics and staff. Their supporters argue that these laws aim to protect maternal and fetal health. Clinics often struggle to meet the requirements TRAP laws impose, making it difficult for them to stay open. Ultimately, the ulterior motive of TRAP laws is to render abortion inaccessible (Medoff 2012, 240-1).

activity are not mediated by public anti-abortion attitudes or state mass ideology (Medoff 2002, 481).

State mass political ideology

Evidence of the impact of state political ideology—or the extent to which a state population identifies as liberal or conservative—on abortion laws is varied. In the post-*Roe* era, conservative ideology generally has become linked with an anti-abortion rights stance, and liberal ideology is associated with a pro-abortion rights view. Schnell (1993) asserts that individuals with socially conservative views, such as a preference for traditional sexual morals and rigid gender roles, are more likely to endorse anti-abortion views than those with liberal views. Saad (2002) reports a similar finding, remarking that Americans who believe abortion should be legal under only limited circumstances are twice as likely to identify as politically conservative than politically liberal. According to Camobreco and Barnello (2008), these views have become increasingly likely to be translated into policy due to growing elite responsiveness to mass political ideology in the context of abortion policy. As a result, they contend, there is now a significant negative relationship between the proportion of a state's population that identifies as liberal and the restrictiveness of the state's abortion laws (57). Conversely, they also find a positive relationship between the proportion of a state's population that identifies as conservative and the restrictiveness of its abortion laws (Camobreco and Barnello 2008, 57).

However, several studies fail to find a relationship between mass political ideology and the restrictiveness of state-level abortion laws. For instance, Cohen and Barrilleaux (1993) observe that mass-level political ideology does not predict whether a state will pass legislation that would add an amendment to its constitution banning abortion (210). Medoff (2002) also argues that political ideology does not affect the likelihood that a state will enact abortion

restrictions. However, these studies were published fifteen and six years, respectively, before Camobreco and Barnello (2008), which found that political ideology did not impact states' abortion laws until 2003. Since Camobreco and Barnello (2008) assert that the influence of mass ideology on abortion laws has steadily increased since *Roe*, it is possible that Medoff (2002) would find a relationship between ideology and state-level abortion law restrictiveness if he were to replicate his study using more recent data.

Partisan control of state government

Elected officials from both the Republican and Democratic parties have become increasingly polarized in their position on abortion since 1973. This polarization crystallized in its modern-day form in 1980, when the GOP included an amendment in its national party platform announcing its support for a “human life amendment” to the Constitution (Tatalovich and Schier 1993, 118-21). The enactment of such an amendment would have overturned *Roe*. Thus, at this point, the GOP no longer framed abortion as a form of healthcare accessible only to white, middle- to upper-class, and Protestant women. Rather, abortion had come to symbolize the emergence of second-wave feminism and women's sexual liberation, alienating the “socially conservative Republican Protestants” who constituted approximately half of the GOP's national base (Williams 2011, 522).

Since then, congressional Republicans have become increasingly likely to support restrictions on abortion, while congressional Democrats have become more likely to both oppose abortion restrictions and support bills that facilitate access to abortion (Adams 1997). These deepening partisan cleavages have manifested at the state level, as well. For instance, Norrander and Wilcox (1999) demonstrate that a state's historical “policy culture” influences the abortion policy it produces (716). That is, state legislatures with a history of enacting mostly liberal

policies will also pass liberal abortion policies, and the abortion policies of states with a record of enacting mostly conservative policies are likely to be more restrictive.

Further, Norrander and Wilcox (1999) argue, Democratic control of both chambers of a state's legislature is negatively associated with the enactment of abortion restrictions. Likewise, Medoff (2012) and Medoff and Dennis (2011) add that partisan control of a state government directly affects whether a state enacts a TRAP law. When Republicans control both chambers of a state's legislature and governor's office, the state will be more likely to enact a TRAP law; when there is unified Democratic control of a state's government, the state will be less likely to enact a TRAP law. These results remain consistent regardless of the level of anti-abortion interest group strength or the state population's abortion attitudes and ideology (Medoff 2012, 257; Medoff and Dennis 2011, 951). Moreover, Medoff (2002) finds that when there are more female Democratic legislators in a state, the state will be less likely to enact abortion restrictions (481). From these findings, it appears that partisan institutional control is a primary influence on state-level abortion policy (Medoff 2012).

Anti-abortion clinic violence, demonstrations, and sidewalk counseling: overview and effects on abortion rates

A fifth factor that may influence the likelihood that a state will enact an abortion clinic access law is the prevalence of violence, harassment, and protests targeted at the state's reproductive health clinics. The National Abortion Federation ("NAF;" 2017) and the Feminist Majority Foundation ("FMF;" 2017) report that levels of violence targeted at clinics, threats of violence against clinic staff, and general clinic-based harassment have fluctuated since abortion

was first decriminalized but have steadily increased in recent years (NAF 2017; Jerman and Jones 2014; Henshaw and Finer 2003).⁶

Doan (2007) remarks that all forms of harassment and violence targeted at reproductive health providers, clinics, and patients serve the purpose of the anti-abortion movement: to recriminalize abortion or to render the procedure inaccessible (114). Conservative Christian fundamentalist sentiment and a commitment to the notion that abortion is immoral provide the basis for mobilization (Blanchard and Prewitt 1933, 216). The anti-abortion movement, Doan (2007) posits, has three branches. The first branch is the “political action” branch, which supports both anti-abortion lawmakers and legislation that undermines access to reproductive healthcare clinics. The second is “the outreach branch,” which seeks to counsel women to keep unwanted pregnancies. This branch’s work often centers on establishing and operating crisis pregnancy centers. These centers aim to persuade pregnant women to keep their babies or assist them with the adoption process (Doan 2007, 106). Finally, the last branch is “direct action” groups, which target “nongovernmental actors” (Doan 2007, 107). The activities of direct action groups range widely. Some engage in and promote acts of domestic terrorism, like the murder and kidnapping of abortion providers as well as clinic bombings and arsons (Doan 2007, 108; Mason 2004). The Army of God, a leaderless organization of violent extremists, is perhaps the most prominent example of this kind of direct action group (Bartholomew 2012, 17-8; Doan 2007, 108-9). Members of the Army of God kidnapped and murdered abortion providers,

⁶ In their analysis of the accessibility of abortion services in the United States, Jerman and Jones (2014) found that the proportion of reproductive health clinics in the United States that have experienced some form of anti-abortion harassment, such as picketing, harassing phone calls, clinic obstruction, noise disturbances, vandalism, picketing the residences of clinic staff, and bomb threats increased from 56% to 84% from 2001 to 2011 (422; see also Henshaw and Finer, 2003). Picketing in particular has been one of the most common forms of clinic harassment since 1977 (NAF 2017, 3-6). Around 80% of clinics experienced picketing between 1985 and 2000 and in 2011, and 53% of clinics reported that they were picketed at least 20 times in 2011 (Henshaw and Finer 2003; Jerman and Jones 2014, 422).

bombed clinics, and perpetrated anthrax threats against clinics from the early 1980s into the 2000s (Blanchard and Prewitt 1993, 189-190; Doan 2007, 109). Other groups in this branch use dangerous but less extreme methods, such as the Pro-Life League (the oldest anti-abortion activist group in the U.S.) and Operation Rescue. These groups blockade and picket clinics to limit abortion access and disrupt clinics' operations (Doan 2007, 106). Members of direct action groups also participate in "sidewalk counseling," during which they approach women entering clinics to discourage them from having abortions, offer them anti-abortion literature, and give them directions to nearby crisis pregnancy centers (Pérez 2017, 58; Lithwick and West 2014; Doan 2007, 122).

Not all direct action groups officially promote illegal or violent means of disrupting abortion services. Nonetheless, their "rhetorical absolutism as well as the individualized nature of protest activities" polarizes clinic environments and fuels aggressive protest tactics that may threaten or harm abortion providers, clinic escorts, and patients (Doan 2007, 107). Indeed, these varying streams within the direct action branch all eventually came to endorse a similar fundamentalist "apocalyptic" ideology by the 1990s: the notion that life merits protection at all costs, and that death, violence, and coercion are justified as means to this end (Doan 2007, 28; Mason 2004, 809).

Research suggests that anti-abortion clinic violence and harassment affects abortion rates, another potential determinant of clinic access law enactment, by decreasing the availability of abortions in a manner similar to statutory abortion restrictions. That is, they reduce the supply of abortion services rather than the demand for them (Jacobsen and Royer 2011, 221). First, anti-abortion activists seem to target states with higher abortion rates (Freilich and Pridemore 2007, 330-1; Jacobsen and Royer 2011, 221; Medoff 2003, 279; Nice 1988, 186-7). Higher abortion

rates suggest that abortion is relatively accessible in a state, and consequently, that the anti-abortion movement is failing to achieve its goals there (Freilich and Pridemore 2007, 330-1; Nice 1988). These circumstances may indicate the necessity of taking aggressive and concentrated extralegal action to anti-abortion activists. Further, Freilich and Pridemore (2007) add, higher abortion rates may also simply imply that there are greater numbers of clinics and abortion providers within a state, creating more targets for direct action (331).

Clinic-based violence, demonstrations, and harassment reduce abortion rates by causing clinics to close due to staff attrition, medical providers' refusal to perform abortions out of fear for their safety, extensive damage to clinics, and prohibitive security costs (Doan 2007, 118; Jacobson and Royer 2011, 209). Indeed, Kahane (2000) demonstrates that at the county-level, anti-abortion harassment of clinic patients is positively correlated with a 19% reduction in the county abortion rate and a 4.3% rise in the price of abortion, which suggests that picketing, protests, and violence at abortion clinics dampens the ability of clinics to supply abortion services (477).

It is difficult to study whether anti-abortion protests, picketing, harassment, and violence directly dissuade individuals from seeking abortions, and research on this topic offers mixed results. On one hand, scholars have shown that anti-abortion activities tend to trigger moderately negative feelings in women who have seen or interacted with protestors (Cozzarelli et al. 2000, 275; Doan 2007, 118; Foster et al. 2013, 86). However, it is unclear whether and how often clinic violence and harassment totally deter individuals from seeking abortion services. Although anti-abortion activities can trigger a decrease in the county-level abortion rate, they may not influence the abortion rate in the long run. In counties affected by anti-abortion violence, the abortion rate falls and the birth rate rises slightly in the short-term, while the abortion rate rises in neighboring

counties with lower levels of violence (Jacobson and Royer 2011). These findings imply that anti-abortion violence may compel individuals to seek abortion services in safer counties nearby but does not completely discourage them from pursuing the procedure (Jacobson and Royer 2011, 218-221). Ultimately, clinic protests, picketing, and violence appear to affect “the market for abortions” through the supply of abortion services rather than the demand for abortion (Jacobson and Royer 2011, 221). In other words, anti-abortion activities have a greater long-term negative impact on clinics’ ability to provide the procedure rather than on the demand for it.

Percent of female state legislators

The percent of female legislators in a state may also affect the likelihood that the state will enact a clinic access law. It is often assumed that women legislators are more likely than their male colleagues to advocate for policies involving what are perceived as “women’s issues,” such as women’s health care, childcare, domestic violence, and policies impacting family life (Carroll 2001, 3; Reingold 2000, 14). Sapiro (1981) posits that this gendered difference in legislative behavior emerges through social processes. Women have developed a unique set of political, economic, and social interests as a result of their subordinate “social position” in a patriarchal society (Sapiro 1981, 703). Theoretically, descriptive representation of women (the presence of women in public office) may increase the likelihood of their substantive representation (the introduction of and support for women’s particular concerns in political bodies) (Reingold 2000, 33). Women legislators may be more inclined to advocate for and protect those who they perceive as sharing their life experiences—their female constituents (Phillips 1995, 52-3; Reingold 2000, 38).

Female legislators themselves often assert a claim to this unique gendered perspective and ability to engage in substantive representation of women, arguing that they are more adept

than their male counterparts at representing facets of the “private sphere” like women, children, and families (Reingold 2000, 14-5; 27; 319). Literature on women in political office provides some support for this presumption. Women state legislators in several states of varying political cultures are much more likely than their male colleagues to prioritize bills dealing with issues that affect women, children, and families (Thomas and Welch 2001, 172). Similarly, women legislators in California and Arizona reported that they devoted more time and effort to communicating with, understanding, and advocating for their constituents, with special concern for their female constituents (Reingold 2000, 240-44).

Crucially, the literature suggests that institutional factors heavily influence the ability of female legislators to substantively impact a state’s policymaking environment. For one, past findings in the literature on state legislatures generally suggest that women legislators tend to engage in substantive representation through agenda setting and issue advocacy rather than roll call voting behavior (Reingold 2006, 3; Reingold 2000, 245). Women legislators who endorse feminist viewpoints may not advocate for these views while campaigning or vote in accordance with them once in office. They may fear the possibility that the public and/or their colleagues will perceive them as being motivated solely by their gender (Carroll 1984). Additionally, female legislators may require a base of support and a network of likeminded colleagues before they begin to assert their perspective as women and/or feminists in state legislatures. Saint-Germain (1989) and Thomas and Welch (2001) find that a critical mass of women state legislators is necessary before women legislators can exert a sustained impact on policymaking, both in areas concerning traditional women’s issues and other forms of policy.

Literature on the links between women’s representation and specific forms of abortion policy is sparse and has generated a range of results. Overall, female legislators are generally

more liberal than their male colleagues and are more likely to be pro-choice (Berkman and O'Connor 1993, 110; Swers 1998, 445). As a result, it appears that the proportion of female legislators in a state is negatively correlated with the restrictiveness of the state's abortion policies (Medoff 2002, 487). Norrander and Manzano (2011) show that states with higher proportions of female Democrats are more likely to enact more liberal abortion policies, regardless of the party in control of the state's government (10). At the same time, Berkman and O'Connor (1993) find that female Democratic state legislators have the most influence on the enactment of symbolic abortion policies and do not significantly affect policies that treat abortion like a social welfare issue.⁷ Symbolic abortion policies are those that allow states to announce their position on abortion, family values, and motherhood without directly facilitating or denying access to abortion (Berkman and O'Connor 1993, 104-5). Moreover, like TRAP laws and clinic access laws, symbolic policies may not be as salient or simple as other forms of abortion policy. Thus, they may be less likely to spark polarized mobilization along anti-abortion and pro-choice lines (Medoff 2012, 239; Medoff and Dennis 2011, 952). Consequently, pro-choice women legislators may perceive their votes on symbolic abortion policies as a low-risk means of ensuring their female constituents of their continued support for abortion access (Berkman and O'Connor 1993, 112).

State approach to gender-based violence

Another factor that may influence the probability of state-level clinic access law enactment is a state's approach to gender-based violence. Past literature demonstrates an apparent relationship between a state's approach to gender-based violence and rates of anti-

⁷ Specifically, Berkman and O'Connor (1993) find that the proportion women Democratic legislators in a state is significantly negatively correlated with the likelihood that a state will enact a law requiring minors to notify their parents before getting an abortion. Yet, women Democratic legislators are not a significant predictor of the likelihood of the creation of restrictions on public funding for abortion (108-9).

abortion violence, independent of state political elite ideology and partisan control of the government. First, using theory on political violence and social movements, Nice (1988) argues that a state culture of apathy towards violence against women may signal to anti-abortion activists that clinic violence and harassment will be met with little to no consequences (180). He finds that, during the 1980s, states with higher rates of rape and female homicides were far more likely to experience abortion clinic bombings than those with lower rates. Moreover, states with stronger protections against domestic violence were much less likely to experience clinic bombings (Nice 1988, 186-7). Likewise, Freilich and Pridemore (2007) suggest that state-level female homicide rates are significantly positively correlated with rates of clinic vandalism (330). Bartholomew (2012) also asserts that rates of rape are significantly positively correlated with levels of clinic violence, property attacks, harassment, and vandalism (90-1). These findings indicate that those who engage in clinic violence and harassment may follow a rational choice model when engaging in anti-abortion activity. High rates of gender-based violence and minimal legal protections for survivors indicate the low opportunity cost of anti-abortion clinic activity in a state (Bartholomew 2012, 27).

Although no research has been conducted on the link between elite cues concerning gender-based violence and the enactment of clinic access laws themselves, political elites often draw explicit connections between violence against women and these policies. For example, the provision of California's access law protecting clinic staff member's identities was enacted through a statute that provides survivors of domestic violence with resources and identity protection (Cohen and Cannon 2015, 212). Further, Senator Edward Kennedy defended FACE on the grounds that it was meant to protect against "violence—violence against women, violence against doctors, violence against nurses" (as cited in Cohen and Cannon 2015, 207). In this light,

it seems that rates of gender-based violence may influence the probability of access law passage in two opposing ways. Higher rates of gender-based violence could drive up clinic violence and harassment, which might compel even reluctant political elites to support an access law. Alternatively, lower rates of gender-based violence may indicate a state's willingness to legislatively respond to any level of clinic violence and harassment.

Classifying State-Level Abortion Policies as Morality Policies or Redistributive Policies

Scholars have typically conceptualized abortion policy as “morality policy,” categorizing it with other controversial policies such as gay rights and capital punishment (Kreitzer 2015a, 31; Mooney and Schuldt 2008). Haider-Markel and Meier (1996) define morality policies as those where, throughout the policymaking process, “at least one advocacy coalition involved has portrayed the issue as one of morality or sin and used moral arguments in its policy advocacy” (333). Thus, policies become part of the morality framework through framing choices—not necessarily as a result of their actual content or effects (Mucciaroni 2011, 188-9). Still, morality policies are “technically simple” and highly salient (Mooney 2001, 7, as cited in Kreitzer 2015a 15). They also affect deeply held beliefs and values. Together, these conditions provoke relatively high levels of mass and elite polarization and grassroots activity (Mooney 2001, 7-8, as cited in Kreitzer 2015a, 15-6). Since the characteristics of morality policies drive higher levels of citizen awareness, opinion formation, and political participation, political elites are quite responsive to public opinion, attitudes, and ideology in the decision-making processes associated with these policies (Camobreco and Barnello 2008, 57). Abortion policy often displays these characteristics (Cook, Jelen, and Wilcox 1996).

Redistributive policies, in contrast, “transfer benefits, expenditures, or resources from one group or class to another (Greenberg and Page 2009, as cited in Medoff 2012, 952). In contrast to

morality policies, redistributive policies rarely touch on core values, or at least, they are not framed this way (Kreitzer 2015a, 65-6; Medoff 2012, 951-2; Mucciaroni 2011, 192).

Consequently, mass-level forces are weaker predictors of these kinds of policies (Goggin 1993; Kreitzer 2015a, 65-6; Medoff 2012). In other words, elites rely on their own policy preferences and technical expertise when producing redistributive policies. Unlike most previous scholarship, Medoff (2012) and Medoff and Dennis (2011) classify “substantive” restrictions on abortion, such as TRAP laws, as redistributive policies rather than morality policies since they drive down the supply of abortion services (Medoff and Dennis 2011, 968).

Since *Roe*, interest groups, the American public, and political elites have increasingly perceived the debate over abortion as a battle between conservative “pro-life” or anti-abortion and liberal “pro-choice” groups. The rise of the conservative Religious Right during the 1980s—and subsequent liberal Democratic pushback—ingrained this dichotomization into American politics. This development positioned the GOP as the pro-life/anti-abortion rights party and the Democratic Party as pro-choice/pro-abortion rights party (Goggin 1993, 14-8; Tatalovich and Schier 1993, 118-21). Due to the seemingly simple, binary nature of abortion politics, the vast majority of Americans have formed an opinion on the issue (American National Election Study 2012). Abortion attitudes have become such a powerful political motivator that they have been shown to affect citizens’ voting behavior independently of partisan affiliation and ideology (Cook, Jelen, and Wilcox 1994). As previously discussed, several scholars have found a direct link between public anti-abortion attitudes and the restrictiveness of state-level abortion policy, suggesting that the mass public has a particularly strong influence on the content and enactment of many abortion policies (Camobreco and Barnello 2008; Norrander and Wilcox 1999).

More recent literature, however, has demonstrated that certain state-level abortion policies may not fall neatly into the morality policy classification. Kreitzer (2015a; 2015b) finds that legislative abortion restrictions match the morality policy framework more than pro-abortion rights policies do. The predictors of morality policy that she identifies—public opinion on abortion and the religious adherent rate in a state’s population—significantly predict the enactment of abortion restrictions, but only public opinion predicts the enactment of pro-abortion rights policies (55). Similarly, state public abortion attitudes, mass political ideology, the percent of Evangelical Christians and Catholics in a state’s population, and state abortion rates do not significantly predict the enactment of TRAP laws (Medoff 2012, 256-8; Medoff and Dennis 2011, 967-9). Rather, variables measuring partisan institutional control do. Using these results, Medoff and Dennis (2011) and Medoff (2012) categorize TRAP laws as redistributive policies, not morality policies: state political elites are not responding to public pressures when passing TRAP laws.

TRAP laws indirectly control the supply of abortion services by imposing stringent regulations that can lead to staff attrition and clinic closures (Medoff 2012, 240-1). Further, they regulate clinic environments and infrastructure rather than abortion itself, making them more complex and less explicitly morally fraught than other forms of anti-abortion rights policy (Medoff 2012, 969). Clinic access laws and TRAP laws bear striking similarities: both are “substantive” abortion policies that display a relatively high degree of complexity (Medoff 2012, 245). Like TRAP laws, then, access laws could perhaps be classified as redistributive policies rather than morality policies.⁸

⁸ Notably, morality policies and redistributive policies may not be mutually exclusive: the process of deciding how and to whom goods and services are distributed inevitably bears moral implications. However, this division does not necessarily stem from the content or actual effects of either policy but how they are framed by political elites, the mass public, and the media. These strategic framing choices in turn produce divergent policymaking processes.

Chapter 3: Research Questions, Hypotheses, and Methodology

In Chapter 3, I utilize the past literature outlined above to construct my research questions and the theoretical basis for my hypotheses. I then describe my data collection and statistical methodologies.

Research Questions, Theories, and Hypotheses

Researchers have used measures public abortion attitudes, anti-abortion interest groups, state political ideology, partisan control of the state legislature and governor's office, and state-level abortion rates to study various influences on state abortion policy (Cohen and Barrilleaux, 1993; Cook, Jelen, and Wilcox, 1993; Medoff 2002; Medoff and Dennis, 2011; Roh and Haider-Markel, 2003). However, to my knowledge, there has not yet been a study that evaluates these variables as predictors of the enactment of clinic access laws. Further, the little research on clinic access laws that exists concentrates on how these laws affect levels of anti-abortion violence and disruption targeted at clinics (Bartholomew 2012). Other work focuses on the tensions between speech and privacy rights that buffer and bubble zone laws have engendered (Wilson 2013). Thus, to fill in this gap in the research, this project aims to answer the following questions: What social, political, and institutional conditions explain why states enact clinic access laws? To what extent does a state's historical approach to free speech influence the likelihood that it will enact a buffer zone law? Are clinic access laws grounded in a morality or redistributive policy framework? I have developed several theories and hypotheses based on the extant literature to answer these questions.

H(1) Past research strongly suggests that state-level abortion policies reflect public abortion attitudes. The stronger the anti-abortion sentiment in a state, the more restrictive its abortion policies become (Camobreco and Barnello 2008; Norrander and Wilcox 1999). Thus, *I*

expect that the greater the percent of individuals endorsing anti-abortion attitudes in a state's population, the less likely the state will be to enact a clinic access law.

H(2) Single-issue interest groups can heavily affect public policy. They often represent the most engaged citizens whose support, funding, and expertise are crucial to political candidates' election or reelection (Medoff 2012; Medoff and Dennis 2011). The percent of a state's population that identifies as Catholic or Evangelical Protestant can serve as a useful proxy measure for the strength of anti-abortion interest groups in a state. The Catholic Church and Evangelical denominations tend to politicize their members' religious anti-abortion sentiments (Blanchard and Prewitt 1993; Doan 2007; Medoff 2012; Medoff and Dennis 2011; Munson 2008; Norrander and Wilcox, 1999). As the percent of Evangelical Protestants and Catholics in a state population grows, the members of the direct action branch of the anti-abortion movement in that state may rise as well, heightening levels of clinic violence and harassment and perhaps increasing the probability that a state will enact a clinic access law to deter this activity (Bartholomew 2012; Blanchard and Prewitt 1993; Doan 2007; Mason 2004; Munson 2008). At the same time, large numbers of Evangelicals and Catholics in a state could boost the strength of the anti-abortion movement's political action branch there, enabling this branch to mobilize against pro-abortion rights policies (Bartholomew 2012; Blanchard and Prewitt 1993; Doan 2007; Munson 2008). Given these conditions, *I expect that the percent of Catholics and Evangelicals in a state population will be negatively related to the likelihood that a state will enact a clinic access law.*

H(3) Schnell (1993) and Saad (2002) argue that citizens who endorse viewpoints that are ideologically conservative are more likely to favor restrictions on abortion, and Camobreco and Barnello (2008) find that mass-level political ideology has become increasingly likely to be

translated into abortion-related public policy. Consequently, *I expect that the more conservative a state's mass political ideology, the less likely the state will be to enact a clinic access law.*

H(4) States whose governments are under Democratic control are less likely to enact abortion restrictions (Berkman and O'Connor 1993; Medoff 2002; Medoff and Dennis, 2011; Norrander and Wilcox 1999). Due to methodological constraints, this study uses a measure of state political elite ideology rather than measures of partisan control (Berry et al. 2010). Since the partisan realignment of the 1980s, the Democratic Party has generally endorsed a liberal ideology, and the Republican Party has endorsed a conservative ideology (Petrocik 1987). Consequently, *I predict that states with more liberal governments will be more likely to enact a clinic access law.*

H(5) Given that states enact clinic access laws in response to clinic-based violence and harassment, *I expect that clinic violence and property damage will be positively associated with the likelihood that a state will enact a clinic access law.*

H(6) Generally, female state legislators are more liberal and pro-choice than their male counterparts (Berkman and O'Connor 1993; Norrander and Manzano 2011; Swers 1998). Further, female legislators make a particularly strong impact on abortion policies that are relatively complex and perhaps less polarizing, such as parental notification laws (Berkman and O'Connor 1993). Thus, *I predict that the higher the percent of female legislators in a state, the more likely the state will be to enact a clinic access law.*

H(7) Bartholomew (2012), Freilich and Pridemore (2007), and Nice (1988) utilize rates of rape and female homicide to capture a state's tolerance of gender-based violence. These rates offer a surrogate measure of the cues that states send to anti-abortion activists, where heightened rates of "violent female victimization" indicate a sociopolitical environment that is accepting of

anti-abortion clinic violence and harassment (Bartholomew 2012, 76-7). Past research strongly suggests that higher rates of rape may invite increased clinic violence and harassment, generating significant public safety concerns (Bartholomew 2012; Freilich and Pridemore 2007; Nice 1988). These conditions likely raise the possibility that political elites will support an access law due to public pressure. Consequently, *I predict that the higher a state's rate of rape, the likelier the state will be to enact a clinic access law.*

H(8) Anti-abortion activists target states with higher abortion rates since elevated abortion rates indicate both movement failure and more targets (i.e., clinics, staff, and patients) for violence and harassment. Further, higher abortion rates may also indicate that a state places fewer restrictions on abortion access (Freilich and Pridemore 2007; Jacobsen and Royer 2011; Medoff 2003; Nice 1988). In light of these mechanisms, *I hypothesize that the higher a state's abortion rate, the likelier it will be to enact a clinic access law.*

H(9) Since most clinic access laws were created after the federal clinic access law was enacted in 1994, *I predict that the presence of the FACE law will be negatively associated with the likelihood that a state will enact a clinic access law.*

H(10) To my knowledge, there is no preexisting measure of a state's support for free speech. In this study, I create a proxy measure of this variable using state reporter shield laws, or laws that allow reporters the privilege to refuse to testify on information obtained from confidential sources (Campagnolo, 2003; Jones 2013). These laws aim to protect investigative reporters and the First Amendment rights to freedom of speech and the press (Jones 2013).

Buffer zone laws have been challenged on the grounds that they overburden anti-abortion protestors' First Amendment right to free speech (Hill 2000; McCullen 2014). Using the reporter shield law variable, I will investigate why states enact buffer zone statutes instead of or in

addition to laws that lack such strong speech-related implications, such as those that prohibit damage to and obstruction of clinics and/or harassment of patients and employees. Since reporter shield laws offer heightened protection for freedom of speech, *I predict that states that have enacted shield laws will be less likely to enact a buffer zone law.*

H(11) Finally, Medoff (2012) and Medoff and Dennis (2011) find that TRAP laws are enacted through a redistributive policymaking mechanism—not a morality-based one—since they are better predicted by institutional variables rather than mass-level factors. TRAP laws are not explicit restrictions on abortion but regulations of clinic infrastructure and staff, making them technically complex and less polarizing than other forms of abortion policies (Medoff 2012; Medoff and Dennis 2011). Nor are TRAP laws symbolic policies: they impact the availability of abortion services in measurable and concrete ways (Medoff 2012, 245). Clinic access laws are quite similar to TRAP laws. They regulate abortion access indirectly by shaping clinic environments and deterring anti-abortion activity (Bartholomew 2012). Further, debates surrounding these laws often broach policy areas other than abortion, such as speech rights and public safety (Wilson 2013). As a result of these conditions, the policymaking process involved in generating clinic access laws may not spark robust polarization and mobilization along anti-abortion/pro-choice and liberal/conservative lines.

Consequently, it is likely that the institutional control factors included in this study (state political elite ideology and the percent of female state legislators) will be stronger predictors of the likelihood of clinic access law enactment than measures of mass-level policy preferences and ideology (anti-abortion attitudes, anti-abortion interest group strength, state mass political ideology, and abortion rates). Thus, *I expect that the results will demonstrate that clinic access laws will be more easily categorized as redistributive policies than morality policies.*

Data Collection and Methodology

Dependent variable data collection

To collect data on states' clinic access laws, I used information provided by the Guttmacher Institute, a nonprofit dedicated to researching and promoting reproductive healthcare policies. The Institute has compiled a list of the states that have clinic access statutes and an overview of the contents of these statutes that it continuously updates. Further, the Institute's researchers also made available via email more detailed information on where these laws are located in their respective states' codes (Ansari-Thomas via personal correspondence 2016). Using this information, I identified the years in which the laws were enacted using several sources. The first source was NARAL Pro-Choice America's "State Governments" site, which contains a list of all state-level abortion policies and the years in which they were passed. This information was also cross-checked with the appendices in Bartholomew's (2012) study, which include information on when the laws were passed, a table displaying the overview of their contents, and the text of the laws themselves (122-148). Information on the content of clinic access laws, the laws' locations in their respective state's codes, and the years in which the laws were enacted is included in Appendix A.

I then created a dummy variable using this data. If a state enacted a clinic access law during one of the years between 1973 and 2014, I coded this variable as "1" in the year it did so. I coded this variable as "0" in the years in which a state did not enact a clinic access law.⁹ In

⁹ New Hampshire's buffer zone law was created in 2014, but it has not been enforced (Guttmacher Institute 2018). For the purposes of this study, this condition was largely irrelevant. This study seeks to understand why these kinds of laws are enacted in the first place. Thus, subsequent non-enforcement of an access law does not affect the clinic access dummy variable at hand. Additionally, Massachusetts amended the provision of its law that creates a buffer zone once in 2007 (expanding the buffer zone to 35 feet) and again in 2014 (narrowing the buffer zone in response to the Supreme Court's decision in *McCullen*) (Tietjen 2014). In this study, the access law dummy is coded as "1" only in 1993, the year the state enacted its obstruction and threat provisions, and in 2000, the year that the original buffer zone legislation was passed (Bartholomew 2012, 147; Guttmacher 2018; NARAL 2018). This method

cases when a state added multiple provisions to its law in different years, I coded the access law dummy variable as “1” in those years, as well. The states that enacted multiple provisions were California, Massachusetts, and North Carolina (Ansari-Thomas via personal correspondence 2016; NARAL 2018; Bartholomew 2012 146-8).

Independent variable data collection

The literature has identified five main determinants of state-level abortion policy: public abortion attitudes, the strength of anti-abortion interest groups, state political ideology, partisan control of the state legislature and governor’s office, and state-level abortion rates (Cohen & Barrilleaux, 1993; Medoff and Dennis, 2011). I compiled data on each of these variables—with some slight variations—in order to analyze how they influence clinic access law enactment. Additionally, given that states pass clinic access laws in response to clinic violence, I also collected data on incidents of clinic violence and property damage within each state. Data were also collected on rates of rape, the percent of female legislators in each state, and reporter shield laws. I used data from all states and DC, and for most variables, I included data for every year between 1973 (the year that abortion was nationally decriminalized) and 2014 (the year the last clinic access law was enacted).¹⁰ The data came from several different sources that the literature has shown to be valid and reliable.

Public abortion attitudes. To collect data on public abortion attitudes, I used data from the Pew Research Center. Pew’s Religious Landscape Study (2014) compiled information on the percent of adults in each state who believe abortion should be legal in all/most cases, illegal in all/most cases, and those who don’t know. In line with past literature, I incorporate only public

ensured that the dummy variable was measuring the same kind of event—the creation of a clinic access law and the addition of entirely new provisions to it—across all states.

¹⁰ For each state, there were 42 observations—one for every year in the data set.

anti-abortion attitudes in my analyses (Medoff 2012; Medoff and Dennis 2011). Since anti-abortion attitudes have been shown to be remarkably stable since *Roe*, I applied the 2014 data to all years in the dataset (Rosenberg 2015, 245).

Strength of anti-abortion interest groups. I measured the strength a state's anti-abortion interest groups using the percent of Catholics and Evangelical Protestants in the state, as per Medoff and Dennis (2011) and Medoff (2012). The Association of Religion Data Archives provided information on the percent of Catholics and Evangelical Protestants in the years 1980, 1990, 2000, and 2010 as part of its 1980-2010 Religious Congregation and Membership Studies. I applied the data from 1980 to the years 1973-1989, 1990 data to 1990-1999, 2000 data to 2000-2009, and 2010 data to 2011-2014.

State mass political ideology. Erikson, Wright, and McIver (1993) construct a measure of state political ideology using CBS News/New York Times national polls from 1976 to 2011. Each year in this time period is assigned a score: the percent of a state's population that identifies as liberal minus the percent that identifies as conservative averaged over the prior four years (Medoff 2012, 219). In this construction, negative scores indicate that a state population leans conservative, and positive scores demonstrate that a state population leans liberal. I compiled these data for the years 1976 to 2014 using the database produced by the Institute for Public Policy and Social Research (IPPSR) at Michigan State University (Jordan and Grossman 2014). In their studies of state abortion politics and the enactment of abortion restrictions, Medoff and Dennis (2011) and Medoff (2012) apply the 2003 Erikson, Wright, and McIver (1993) scores to the period between 2004 and 2008. In this vein, I used the data from 1976 for the years 1973-1974. I also applied the 2011 data to the years 2012-2014. Data were missing for 1973-1994 for Hawaii and Alaska. For these states, I applied the available data for 1995 to the years between

1990 to 1994 to decrease the number of missing observations. In the final analyses, these two states still did not have data for this variable for 1973-1989.

Ideological/partisan control of the state government. The literature on more recent abortion policies measures institutional partisan control with indices of Democratic or Republican unified control of state governments or the proportion of state assembly seats held by Democrats and/or Republicans (Berkman and O'Connor 1993; Medoff 2012; Medoff and Dennis 2011).

This study, however, operationalizes institutional control using a measure of state government ideology created by Berry et al. (2010) in order to account for partisan realignment during the 1980's. During this time period, the core coalitions of the Republican and Democratic parties began to erode as "white southerners, Catholics, and labor households—the mainstays of the New Deal Democracy" began to increasingly identify as Republicans rather than Democrats (Petrocik 1987, 354). The Berry et al. (2010) score identifies the partisan composition of each chamber of a state's assembly and the partisan affiliation of the state's governor, then weights these measures using the NOMINATE scores of the state's congressional delegation. The NOMINATE score utilizes the roll call voting behavior of the state's representatives and senators to create an ideology score. Ultimately, the Berry et al. (2010) measure places a state government on a scale of 0 to 100, where 0 is conservative and 100 is liberal (Hicks et al. 2015, 23). I collected these data for the years 1973 to 2014 using the IPPSR database (Jordan and Grossman 2016). There were no data on DC for this measure.

Abortion clinic violence and property attacks. Following in part Bartholomew's (2012) methodology, I used three sources of data for this variable.¹¹ Two were online sources: the

¹¹ I requested access to Brad Bartholomew's more comprehensive data set, which includes data from the NAF, GTD, *Targets of Hatred, Political Violence and Terrorism in Modern America* by Christopher Hewitt (2005), data

National Abortion Federation's (NAF) database on incidents of clinic violence and the Global Terrorism Database (GTD). Both of these databases have compiled information on abortion clinic violence from 1976 to the present. The third source was *Targets of Hatred: Anti-Abortion Violence* by Patricia Baird-Windle and Eleanor J. Bader (2001). Using media sources and first-person narratives of reproductive health clinic staff members from across the US, this book provides a detailed timeline of major events in the development of abortion politics and abortion clinic violence, protests, and blockades from 1966 to 2000. I organized incidents collected from these sources in a database that includes each incident's unique identification number, date, city, state, target, perpetrator, resultant arrests, attack type, as well as information on if the attack was successful,¹² if property damage occurred, the damage amount, weapon used, number of injuries, number of deaths, and finally, a qualitative event description.¹³ I collected information on 373 incidents of clinic harassment and violence from these sources from the years 1977 to 2016.

With this information, I coded each event as either an incident of "Harassment" or a "Violence/Property" attack. This classification largely followed Bartholomew's (2012) methodology, wherein "acts of armed assault, unarmed, assault, assassination, attempted assassination, bombing, attempted bombing, robbery, attempted robbery, hostage taking/kidnapping as well as acts of arson, attempted arson, bombing/explosion, chemical/acid attack, attempted chemical/acid attack, glue in locks, broken windows, acts of sabotage and burglary" were coded as "Violence/Property" attacks (71). I coded incidents of "less severe, yet illegal acts of protest including blockades... death threats, bomb threats, [and]

from the Bureau of Alcohol, Tobacco, Firearms, and Explosives, and the National Counterterrorism Center. However, he was unable to allow me access to it. He recommended that I use the GTD as a starting point for my own data collection (Bartholomew via personal correspondence 2017).

¹² An event was coded as "successful" if it appeared to execute its intended function. Bartholomew (2012) provides the example of a successful clinic bombing: if a bomb was set off in a clinic and it detonated, then the event was coded as successful (158).

¹³ Bartholomew (2012) provides the model for the organization of my own dataset.

chemical/biological threats” as harassment (71-2). Importantly, unlike Bartholomew (2012), I coded facility invasions and vandalism as “Violence/Property” attacks rather than “Harassment.”

Tables 1 and 2 provide an overview of this first round of data collection and organization.

Table 1. Incidents of abortion clinic harassment and violence, 1973-2016, including duplicates.

Type of incident	Number of incidents	Percent of incidents
Violence or property attack	353	95%
Harassment	21	5%
Total	373	100%

Table 2. Incidents of clinic violence and harassment by database.

Database	Number of incidents	Percent of incidents
GTD	253	68%
<i>Targets of Hatred</i>	68	18%
NAF	52	14%
Total	373	100%

Next, I deleted incidents from 2015 and 2016 and identified 49 incident duplicate events based on similarities in event details. I then removed these 49 duplicate events from the clinic violence and harassment database, creating a database of 298 incidents of clinic violence. Table 3 displays the results of these final revisions.

Table 3. Incidents of abortion clinic violence and property attacks, 1973-2014, excluding duplicates.

Type of incident	Number of incidents	Proportion
Violence or property attack	282	95%
Harassment	16	5%
Total	298	100%

In the final dataset, I coded the clinic violence variable as the total number of incidents of clinic violence and property damage per year in each state and DC.

Collecting data on incidents of clinic harassment, protests, picketing, and obstruction posed particular difficulties. Events like these are far less salient than criminal activities like

assault, murder, and vandalism, rendering it difficult to systematically collect, organize, and publish information on them (Jacobsen and Royer 2011, 197-8). The publicly available NAF and GTD databases only display incidents of clinic violence, attacks on abortion providers, and infrastructure attacks. Moreover, while *Targets of Hatred* provides some clinic staff members' detailed narratives of their experience with clinic harassment, obstruction, and protests, the book focuses far more heavily on clinic violence and property damage. Additionally, my attempts to access the NAF's data on clinic harassment aggregated at the state level were unsuccessful (NAF via personal correspondence 2017; 2018). Consequently, I included only incidents of clinic violence and property attacks in the analyses.

Percent of female legislators. I collected data on the percent of female legislators in each state using the IPPSR database (Jordan and Grossman 2016). This database compiled information on the percent of female legislators between 1975 to 2016 using the data provided by the Center for American Women and Politics (CAWP 2006) and Stateminder, a data visualization project at Georgetown University.¹⁴ The IPPSR database does not include information on the percent of female members of the Council of DC, the body that created DC's clinic access law. To impute this data, I retrieved information on the number of female legislators for the years 1975 (data was missing for 1973 and 1974) to 2004 using the archived DC Board of Elections and Ethics website ("Historical Elected Officials," n.d.). To collect data for 2004 to 2014, I used the lists of Council members that Wikipedia provides ("List of members of the Council of the District of Columbia" 2018). For all 50 states and DC, I applied the data from 1975 to the years 1973 and 1974 to reduce the number of missing observations.

¹⁴ While Stateminder is currently listed in the IPPSR database as a source for this data, the project no longer exists.

Rape rate. I collected data for this variable using the IPPSR database and corroborated my findings using the US Department of Justice’s Uniform Crime Reporting Statistics tool, UCR Data Online (Jordan and Grossman 2016). I used rates of “Forcible Rape/Legacy Rape” per 100,000 women in each state from 1973 to 2014. The UCR defines this crime as follows:

The carnal knowledge of a female forcibly and against her will. Rapes by force and attempts or assaults to rape, regardless of the age of the victim, are included. Statutory offenses (no force used—victim under age of consent) are excluded. (Federal Bureau of Investigation 2017).

The UCR collects these data from reporting agencies in all 50 states and DC and creates estimates for years in which no information was reported by a state.

Of the set of independent variables included in the empirical models, the rate of rape is likely to be the most problematic. Unlike rape, anti-abortion harassment and violence are public activities intended to draw attention (Blanchard and Prewitt 1993, 184). Indeed, protests, blockades, and sidewalk counseling occur on roads and sidewalks, which the Supreme Court has defined as prime examples of public fora (O’Neill 1999; Wilson 2013). Nevertheless, this variable offers a straightforward and direct method of capturing states’ tolerance of gender-based violence. Indeed, state-level clinic access laws are often directly linked to broader efforts to decrease gender-based violence (Cohen and Cannon 2015, 212).

Abortion rate. I compiled abortion rates per 1000 women aged 15-44 in each state and DC for the years 1973-2014 from three sources. Data from 1973 to 2005 came from Henshaw and Kost (2008), data from 2007 to 2008 came from Jones and Kooistra (2011), and data from 2011 to 2014 came from Jones and Jerman (2014). Data were missing from years 1983, 1986, 1988, 1989, 1993, 1994, 1997, 1998, 2001, 2002, 2003, 2006, 2009, and 2010. To impute values for these missing years, I calculated the average rates of the years available from the original source immediately before and after the missing data.

FACE Law. I created a dummy variable to account for the enactment of the national-level clinic access law. In the years in the dataset prior to 1994 (1973-1993), I coded this variable coded as “0” for the absence of the FACE law. I coded the years 1994-2014 as “1” to indicate the enactment of the law.

State approach to freedom of speech. I did not find a measure of state support for free speech in past literature. Consequently, I constructed a proxy variable using state laws that have the effect of regulating free speech. I created this proxy measure using states’ reporter shield laws, or laws that allow reporters the privilege to refuse to testify on information obtained from confidential sources (Campagnolo 2003; Jones 2013). Most states—except for Wyoming—recognize reporter’s privilege through a shield law, constitutional provision, or the federal First Amendment (Jones 2013; Student Press Law Center “SPLC” 2014). Since clinic access laws are produced legislatively, this study looks only at reporter shield laws that were enacted by state legislatures. Information on reporter shield laws was collected only on states with clinic access laws.

Using the “State-by-State Guide to the Reporter’s Privilege for Student Media,” I identified the location of each state’s reporter shield statute in the states’ codes (SPLC 2014). Then, with this information, I recorded the year that the law became effective using the text of the statute. Next, I checked this information with “The Reporter’s Privilege,” a compendium on reporter shield laws in all states and DC that the Reporter’s Committee for Freedom of the Press (n.d.) compiles. I then created a dummy variable with this information. In the years before a shield law was enacted, I coded the dummy as “0,” and in the year the law went into effect and subsequent years, I coded the variable as “1.” If a state enacted both a clinic access law and a

reporter shield law, it is listed in the table in Appendix B with the year its reporter shield law was enacted.

Statistical analyses

In order to empirically gauge the extent to which each of the independent variables impacts the likelihood of access law enactment, I used a method of event history analysis. This method aligns with those of Medoff (2012) and Medoff and Dennis (2011), who both employ a form of event history analysis to examine the factors that influence the passage of TRAP laws. This study utilizes a variation of the event history analysis used in this literature. The method here borrows from Carter and Signorino (2010) and the literature on the acquisition of nuclear technology (Brown and Kaplow 2014).

For each of the 50 states and DC, I collected data for the years between 1973 and 2014. Then, to account for “temporal dependence,” I used a cubic polynomial (Carter and Signorino 2010, 1). To construct the cubic polynomial, I created a year count in which I assigned each observation a number that counted the years from the beginning to the end of the dataset. For each state, I assigned the observation in the year 1973 “0,” the observation in 1974 “1,” and so forth (Carter and Signorino 2010). For the states that never enacted clinic access laws, the year count climbed to 41. When a state enacted a clinic access law, I reset this count to “0” in year following the law’s enactment. I restarted the count each time a state added a provision to its clinic access law. Next, I squared and cubed these year counts. Altogether, this process created three new variables: the base year count, the squared year count, and the cubed year count. Finally, I tested the model using logistic regressions, including the original, squared, and cubed year counts as independent variables.

First, I ran logistic regressions on the data set as a whole, including all of the independent variables except for the reporter shield law and using the clinic access law dummy as the dependent variable. Next, to account for partisan realignment and the more gradual emergence of modern-day abortion politics, I narrowed the analyses. I dropped observations from 1973 to 1979 from the data set, and I started the year count variable at “0” in 1980. The squared year count and cubed year count were updated to reflect these changes. Then, I ran logistic regressions on this subset of the data, including all of the independent variables except for the reporter shield law and using the clinic access law dummy as the dependent variable.

Finally, I created another subset of the data using only states that have enacted clinic access laws. I included every independent variable previously discussed in this dataset, and I also added the reporter shield law dummy to this data set to test the second research question (“To what extent does a state’s historical approach to free speech influence the likelihood that it will enact a buffer zone law?”). Further, I dropped the original clinic access law dummy and constructed a new dependent variable in this subset—a buffer zone law dummy. For the states with access laws that lacked a buffer zone, I coded this dummy as “0” for the entire dataset. In the case of states with buffer zone laws (Colorado, Massachusetts, Montana, and New Hampshire), I coded this dummy as “1” in the year that these states passed their buffer zone legislation (1993, 2000, 2005, and 2014, respectively). Additionally, I created a cubic polynomial for this subset of the data. For each state and DC, I used a year count variable to count the years between 1973 and 2014. I reset this year count for the four states with buffer zone laws to “0” in the year after they enacted their buffer zone laws. Again, I squared and cubed this year count, generating three new independent variables that I included in the analyses. Lastly, I ran logistic regressions on this subset of the data using a rare events model (“relogit”) to

account for the fact that I coded the buffer zone dummy variable as “1” only four times in the entire data set (Tomz, King, and Zeng 1999; Tomz, King, and Zeng 2003).

Chapter 4: Results and Discussion

Table 4 displays the results of the logistic regressions run on the entire data set, where the clinic access law dummy variable is the dependent variable. Model 1 includes all independent variables. Model 2 drops the state political elite ideology variable—measured using the Berry et al. (2010) score—since this data were unavailable for DC.¹⁵ The correlation coefficients for each variable are listed with the standard errors. Cubic polynomials were included in both models but are not displayed here.¹⁶ The results in Table 4 below lend credence to several of the hypotheses and provide a point of departure for understanding the mechanisms by which clinic access laws are enacted.

Table 4. Determinants of clinic access laws.

	Model 1	Model 2
Anti-abortion attitudes	-0.003 (0.040)	-0.029 (0.036)
Anti-abortion interest groups	0.020 (0.024)	0.023 (0.023)
Abortion rate	0.048 (0.030)	0.019 (0.012)
Anti-abortion violence and property attacks	0.300 (0.250)	0.326 (0.244)
Mass state political ideology	0.771 (2.179)	1.623 (1.935)
State political elite ideology	0.012 (0.012)	
Percent of female legislators	0.126 (0.038)***	0.105 (0.036)***
FACE	-1.565 (0.659)**	-1.334 (0.625)**
Rape rate	0.012 (0.018)	0.019 (0.016)
Constant	-9.012 (2.881)***	-6.591 (2.387)***
Pseudo R ²	0.143	0.124
N	2,066	2,106

¹⁵ Cubic polynomials were included in both models in Table 4. The year count, squared year count, and cubed year count did not reach statistical significance in either model.

¹⁶ The analyses were first run with logistic regressions and with a rare events logit to account for the fact that the number of clinic access law dummies coded as “0” vastly outweighed those coded as “1.” The same variables—abortion rates, percent of female legislators, the year count, and the squared year count—all remained significant in the rare events logistic regression analysis results. Further, additional logistic regressions were run on data in the post-1980 period to test whether the incorporation of a human life provision in the GOP platform and emergence of modern-day abortion politics influenced the relationships between the variables. The result of this secondary analysis were similar to those reported in Table 4: the percent of female legislators and the enactment of FACE were the only significant predictor of clinic access law enactment.

Coefficients are listed with standard errors in parentheses. *** $p < 0.01$. ** $p < 0.05$. * $p < 0.10$.

Clinic access laws are not entirely separate from moral issues: they regulate the ability of anti-abortion protestors and other more violent activists to express their moral and religious beliefs at clinics. Nevertheless, Table 4 provides evidence that clinic access laws are not produced in response to mass-level factors, such as public anti-abortion attitudes **H(1)**, the strength of anti-abortion interest groups **H(2)**, state mass political ideology **H(3)**, and abortion rates **H(5)**. This suggests that access laws are better classified as redistributive policies than as morality policies **H(11)**.

The fact that many of the predictors tested did not reach statistical significance in either model matches the findings of previous research on pro-abortion rights policies and adds further evidence to **H(11)**. Unlike pro-choice policies, anti-abortion policies are more likely to be morality policies and spark a “clash of absolutes,” where state publics, interest groups, and political elites perceive the debate over these policies’ wording and effects as a zero-sum game (Kreitzer 2015a, 67; Kreitzer 2015b, 46; Tribe 1990). Further, the passage or demise of many anti-abortion policies essentially ensures that one group experiences an infringement upon their closely held values and beliefs (Kreitzer 2015a, 67; Kreitzer 2015b, 46; Luker 1984, 215). However, the content and effects of pro-choice policies such as clinic access laws are more ambiguous and thus lack this polarizing force. Political elites, interest groups, and constituents map discourses about “public safety, freedom of speech or religion, or social welfare” onto these kinds of policies, thereby removing them from the morally, religiously, and emotionally charged rhetoric that typically surrounds anti-abortion regulations and laws (Kreitzer 2015a, 68). Consequently, the paucity of significant predictors within either model in Table 4 is unsurprising. Clinic access laws are pro-choice policies, and they seem to fall outside of the

morality framework. Like other policies with these traits, the relationship between clinic access laws and the explanatory variables that are common in the abortion policy literature is not immediately clear. I now turn to a discussion of each of the findings displayed in Table 4.

First, it was predicted that anti-abortion attitudes **H(1)** and mass political conservatism **H(3)** would reduce the likelihood of clinic access law enactment. While the relationships between these independent variables and the clinic access law dummy fell in the expected directions (negative and positive, respectively), Table 4 demonstrates that neither was statistically significant.¹⁷ These results match those of Medoff and Dennis (2011), who found that public anti-abortion attitudes and mass political ideology are not significant predictors of the enactment of TRAP laws. Clinic access laws, like TRAP laws, are not merely “symbolic” abortion policies whose underlying intention is to signal a state government’s stance on abortion (Medoff 2012, 245). Rather, these laws aim to directly facilitate access to abortion by deterring those who block access to clinics, fuel clinic staff attrition, and engender infrastructural damage that prohibits clinic functioning. Moreover, clinic access laws are often enacted in response to the significant public safety concerns that clinic violence and harassment create. As a result, conventional anti-abortion/pro-choice and liberal/conservative heuristics may not drive the formation of public opinion on these laws. Ultimately, these traits likely drive down grassroots political activity around this type of legislation, reducing the pressure on elites to act in accordance with public abortion policy preferences and mass political ideology during the clinic access law policymaking process.

¹⁷ Recall that in the Erikson, Wright, and McIver (1993) measure of state mass political ideology, a more positive score indicates that a state population leans liberal, and a more negative score indicates that a state population leans conservative.

Further, I hypothesized that the combined percent of Evangelical Protestants and Catholics in a state would provide a grassroots buffer to the passage of access laws **H(2)**. These two groups often join anti-abortion interest and activist groups, make donations to anti-abortion legislators, and lobby state political elites to vote against pro-choice policies (Blanchard and Prewitt 1993; Doan 2007; Medoff 2012, 248; Medoff and Dennis 2011, 958; Munson 2008). However, Table 4 shows that there was not a significant relationship between the anti-abortion interest group variable and the clinic access law dummy. This non-finding may result from many anti-abortion interest groups' decisions to deploy respectability politics by refraining from lobbying against or seriously contesting clinic access laws. Indeed, many nonviolent anti-abortion activists have sought to distance themselves from more destructive and violent extremists since the mid- to late-1980s (Blanchard and Prewitt 1993, 180-5). The Reagan administration and the rise of the Religious Right provided anti-abortion interest groups with significant social, political, and moral victories, lessening the perceived need for extremism and positioning those who did commit anti-abortion violence outside of the mainstream movement (Blanchard and Prewitt 1993, 179; Munson 2008, 110; see generally Doan 2007).¹⁸ Further, the national coverage of anti-abortion arsonists and bombers of the early 1980s had seriously damaged the credibility of the anti-abortion movement by 1988 (Blanchard and Prewitt 1993, 184). The movement's leaders began to push for coercive but nonviolent strategies of "civil disobedience," legal protests, and sidewalk counseling rather than outright violence to recoup its reputation. This change in tactics perhaps established a more amenable tone for the movement

¹⁸ The failure of the Reagan administration to end abortion and the election of Democratic President Bill Clinton in 1992 triggered an increase in violence and harassment during the end of the 1980s and throughout the 1990s (Blanchard and Prewitt 1993, 180-4; Munson 2008, 99). Still, throughout this period, groups that engaged in nonviolent protests and "civil disobedience" continued to distance themselves from extremists (Blanchard and Prewitt 1993, 184-5).

members who viewed themselves as nonviolent and law-abiding activists (Blanchard and Prewitt 1993, 184-5).¹⁹ Ultimately, it may have rendered many anti-abortion activists less likely to contest and more likely to comply with clinic access laws in order to recoup their reputation and preserve their foothold in the broader debate about abortion.

Anecdotal evidence from the state and national levels bears out this theory. Wilson (2013) reports that Colorado clinic picketers and sidewalk counselors in 2004 openly expressed that they accepted the arrest and prosecution of those among their ranks who engaged in violent or destructive activities (122-4). For many of these nonviolent activists, being a “good Christian” necessitated following the law and refraining from harming others (Wilson 2013, 126). The effect of the FACE law further demonstrates this theory. The enactment of FACE in 1994 led to a sharp decline in clinic invasions and blockades, successfully deterring many members of the direct action stream with long jail sentences and heavy fines for these crimes (Cohen and Cannon 2015, 209; Munson 2008, 108). Thus, the tactical and ideological divide between extremist and nonviolent anti-abortion activists may explain the lack of significant correlation between the clinic access law dummy and the anti-abortion interest group strength variable. Most Evangelical Protestants and Catholics, regardless of their membership in and level of commitment to an interest group, may simply be unaware of or reluctant to mobilize against clinic access laws.

Further, the absence of a significant correlation between the anti-abortion interest group strength and clinic access dummy variables may result from the diversity of abortion attitudes

¹⁹ Blanchard and Prewitt (1993) point out that the forms of “civil disobedience” that members of the Pro-Life Action League and Operation Rescue used could be seen as quite radical. Members of these groups blockaded clinics and chained themselves to abortion providers’ cars and clinic entrances (Blanchard and Prewitt 1993, 297, footnote 11). Further, OR and its leader, Randall Terry, generally faced opposition from other leaders in the anti-abortion activist movement for their extreme harassment tactics (Whitehead 1991, 110). However, these tactics are still less dangerous than arsons and bombings, underscoring that more violent and destructive anti-abortion extremists were truly far outside the mainstream.

within the Catholic and Evangelical Protestant denominations, as well as anti-abortion activists' highly variable understandings of the relationship between their faith and activism (Guth, et al. 1993; Masci 2018; Munson 2008, 8). Contrary to popular depictions, the anti-abortion movement is not motivated by static and monolithic religious sentiments (Munson 2008, 7). Rather, the movement's religious roots and contemporary characteristics are quite complex. After *Roe*, the Catholic Church provided the hierarchical structure, financial resources, and religious framing needed to galvanize the movement (Doan 2007, 13; Munson 2008, 85). In contrast, Evangelical Protestants steadily entered the movement after *Roe* but did not consistently constitute a significant portion of its members until the rise of Operation Rescue in 1987 (Munson 2008, 87-8). Moreover, Catholics display a marked diversity in opinion on abortion, while Evangelicals' abortion attitudes are more homogeneous (Masci 2018). Table 5 reflects this movement evolution and these modern-day trends to a moderate degree. Here, the anti-abortion interest group strength variable is broken down into its component parts: the percent of Catholics and Evangelical Protestants in each state and DC during every year in the study. These two separate variables are included in the model in place of the combined anti-abortion interest group strength variable.

Table 5. Results of Logistic Regression Analysis of 50 States and DC, 1973-2014, with anti-abortion interest group variable broken into percents of Evangelical Protestants and Catholics.

	Model 1
Anti-abortion attitudes	-0.035 (0.051)
Proportion of Catholics	0.017 (0.026)
Proportion of Evangelical Protestants	0.063 (0.046)
Abortion rate	0.053 (0.031)**
Anti-abortion violence and property attacks	0.291 (0.252)
Mass state political ideology	1.160 (2.237)
State political elite ideology	0.009 (0.0123)
Percent of female legislators	0.133 (0.040)**
FACE	-.1642 (0.659)
Rape rate	0.008 (0.019)
Constant	-9.094 (3.030)
Pseudo R ²	0.148
N	2,066

Coefficients are listed with standard errors in parentheses. ***p<0.01. **p<0.05. *p<0.10.

The correlation coefficient associated with the Evangelical Protestant variable is larger than that linked to the Catholic variable. Further, while neither variables' p-scores reached statistical significance, the Evangelical Protestant variable's p-score (0.173) is much closer to being significant at the p<0.10 level than the Catholic variable's (0.511). Importantly, the connection between anti-abortion interest group strength and access law enactment remains unclear, and the conclusions that can be drawn from the findings in Table 5 are quite limited. Still, in line with past literature, these findings may indicate that Evangelical Protestants' relatively consistent and clear-cut anti-abortion attitudes make them more likely than Catholics to impact the probability that a state will enact a clinic access law (Guth et al. 1993). These attitudes could provide a galvanizing force for mobilization against clinics, abortion providers, and pro-choice political elites, especially in the context of potentially less salient and more complex abortion policies (Medoff 2012, 251). Further research is needed to investigate these possible connections.

Interestingly, contrary to the expectation of negative directionality, the correlation coefficients associated with the Catholic and Evangelical Protestant variables and with the general anti-abortion interest group variable (shown in Table 4) were positive. Again, the lack of statistical significance in these relationships constrains the conclusions that can be made using these results. Nonetheless, it is possible that increases in the state-level percent of Evangelical Protestants and Catholics are linked with a rise in the likelihood that a state will enact a clinic access law. This result may reflect the relationship between politically active conservative Christian religious groups, rates of clinic-based harassment and violence, and the likelihood of access law enactment. That is, as a state's base of potential religious anti-abortion activists grows, rates of clinic violence, protests, obstruction, blockades, and vandalism may rise, as well. Indeed, Munson (2008) notes the importance of state- and local-level anti-abortion interest groups in movement mobilization. These groups provide the important networks, resources, infrastructure, and nuanced knowledge of state and local culture to produce and sustain religiously motivated political activism (91).

Likewise, the second variable meant to capture state-level anti-abortion activity, the clinic violence and property attack variable **H(5)**, produced another surprising result: it did not reach statistical significance in the models in Table 4 or 5. This result was also puzzling given that states enact clinic access laws in response to clinic violence and harassment (Guttmacher Institute 2018a). It is likely that the absence of a significant relationship here stems from issues with the clinic violence/property attack variable itself. Clinic access laws most often aim to combat sustained and overwhelming "civil disobedience" tactics rather than more serious but isolated crimes like arsons, bombings, and murders (Blanchard and Prewitt 1993 184-5). Only

four states' laws include provisions directly referencing these latter kinds of incidents.²⁰

However, the clinic violence/property damage variable in this study does not measure levels of clinic obstruction, blockades, or demonstrations, rendering it impossible to evaluate the relationship between clinic harassment and the likelihood of access law enactment. Further, it is possible that clinics have responded to anti-abortion violence and property damage through channels other than the legislative process. Clinic staff may hire private security, coordinate with law enforcement, use preexisting local ordinances and state laws, and seek injunctions through the judicial system to push back against anti-abortion activity at clinics (Cohen and Cannon 2015).

Additionally, Model 1 in Table 4 provides no support for **H(4)**, or the prediction that states with more liberal political elites—as measured using Berry et al.'s (2010) weighted measure of state government ideology—would be more likely to enact clinic access laws. The correlation coefficient fell in the expected direction (positive).²¹ Again, it appears that the intersecting discourses on religious, speech, gender-based, and abortion rights that manifest in access law policymaking muddle the laws' symbolic meaning and practical implications. Moreover, they engender unique political stakes. In supporting these laws to ensure that abortion is physically accessible, state political elites may be perceived as encroaching on speech and assembly rights. In opposing them, elites face the possibility that they will be painted as anti-abortion, pro-gendered violence and harassment, and unconcerned about public safety (Kennedy 1994, as cited in Cohen and Cannon 2015, 207). These concerns complicate state legislators' and governors' decision-making during the legislative process.

²⁰ The laws California, Maine, and Washington specifically prohibit damage to clinics. North Carolina's includes a provision banning weapons on clinic grounds (Guttmacher Institute 2018a).

²¹ The Berry et al. (2010) measure assigns an ideology score on a scale of 0 to 100, where 0 is most conservative and 100 is most liberal.

Notably, these cross-cutting pressures on state political elites manifest in the text of access laws themselves and how elites discuss them in state assembly hearings and the media. Often, legislators promote clinic access laws as a means of negotiating the tensions between public safety, privacy rights, and speech rights rather than measures that directly enhance access to abortion.

For example, the first clinic access bill introduced in New York received bipartisan support. It passed in the state assembly, and it was introduced by a Republican in the state senate. Its senate sponsor, Charles D. Cook, gave a positive commentary to the *New York Times* on the legislation. In his statement, he refrained from positioning the issue in a moral or religious context. He remarked, “I think it’s very important that people who are trying to access a health-care facility, for whatever reasons, not be harassed. People who are seeking abortions generally have a lot of problems already. They just don’t need somebody else loading any other problems on their backs” (Myers 1993). Here, he draws on a gender- and morally neutral discourse of public safety and access to healthcare in response to the heavy clinic blockades that had been occurring in the state during the last year. This original access law legislation failed to pass in the state senate. Nevertheless, the state legislature enacted a clinic access law six years later. The law was a response to public outcry about the murder of Dr. Barnett Slepian, an abortion provider, by an anti-abortion sniper at Slepian’s home in Amherst, NY (McKinley 2001; Baird-Windle and Bader 2001, 314-7). This unique policymaking process helps explain why the analyses in this study did not find empirical support for **H(3)**. Legislators deprioritize moral concerns and political ideology in the clinic access law context. Rather, their public safety concerns—or at least, their apparent reaction to their constituents’ fears of anti-abortion extremism and disruption—seem to motivate their legislative behavior.

This tendency towards neutral framing—and thus the blurring of conventional pro-choice/liberal and anti-abortion/conservative divisions at the elite level—is particularly evident in the case of access laws that create buffer and bubble zones around reproductive health clinics. For example, the statement of purpose in the Colorado buffer zone statute explicitly references and clarifies the balancing test between speech and privacy rights, stating that “The general assembly recognizes... that the exercise of a person's right to protest or counsel against certain medical procedures must be balanced against another person's right to obtain medical counseling and treatment in an unobstructed manner...” (Colorado Code § 18-9-122). This language highlights the fact that clinic access laws are not clearly pro-abortion right policies, nor do they specifically seek to prohibit all anti-abortion activities at clinics.

Similarly, prominent pro-choice interest groups engage in this type of framing, as well. Their statements on bubble and buffer zone laws perhaps signal to political elites the importance of creating laws that foster bipartisan political acceptability. When the Montana bubble zone access law was enacted in 2005, NARAL Pro-Choice Montana seized the opportunity to emphasize the importance of defending both speech and abortion rights. The group commended the bill's sponsor, Robyn Driscoll, for crafting legislation that created a “reasonable and responsible balance” between the rights of protestors and those of clinic patients (NARAL Pro-Choice Montana 2005). The president of NARAL Pro-Choice Montana, Maggie Moran, later reiterated these claims after *McCullen* in 2014. In an official statement, she accentuated the protection of speech rights and drew on gender-neutral language: “Buffer zones strike a reasonable balance between the right to free speech and the right to access healthcare and employment without intimidation and violence. Many anti-choice activists protest peacefully, but we cannot ignore the fact that there are some who are violent and harass women and men

entering facilities” (NARAL Pro-Choice Montana 2014). In this light, it appears that clinic access laws—and buffer zone laws, in particular—do not display the same degree of technical simplicity associated with morality policies (Kreitzer 2015a; Kreitzer 2015b; Medoff 2012; Medoff and Dennis 2011; Mooney 2001, 7-8, as cited in Kreitzer 2015a 15-6; Mucciaroni 2011). State legislators and the interest groups that influence their policymaking do not frame clinic access laws as purely abortion-related policies. In turn, this complexity decreases the polarization of elites’ voting behavior.

Further, the text of clinic access laws themselves reflects this theory. The statutes rarely draw on terminology that is particularly polarizing, a tactic that may appease liberal and conservative legislators. For example, the statutes seldom make reference to the term “abortion,” “abortion clinic,” or “reproductive health clinic.” Rather, the majority of the laws simply make reference to “health care facilities” or “medical facilities.” In this way, the statutes approach a greater level content neutrality and bipartisan political acceptability (Wilson 2013, 87-9).²² Table 6 highlights this trend by indicating the location and/or services that each law is intended to regulate.

Table 6. Locations and services regulated by clinic access laws.

State	Location and service referent(s)
California	“Reproductive health services;” “reproductive health services facility;” “health care facility;” “religious services;” “place of religious worship;” “entity that owns or operates a place of religious worship;” “health care facility, place of worship, or school”
Colorado	“Health care facility”
DC	“Health professional;” “medical facility”

²² Content neutrality is a doctrine central to free speech jurisprudence. It is the notion that restrictions on speech must apply equally to all individuals, and that these restrictions must regulate only the time, place, and manner of speech rather than the content of the speech itself (*Ward v. Rock Against Racism* 491 US 781, 1989; Cowan 2001). By construing the notion of health care services and facilities as broadly as possible, states avoid the appearance that they are targeting speech and conduct related only to reproductive health/abortion clinics, and in particular, anti-abortion speech and expressive conduct.

Kansas	“land, nonnavigable body of water, structure, vehicle, aircraft or watercraft, other than railroad property;” “nuclear generating facility;” “Health care facility;” “Health care provider”
Massachusetts	“Medical facility;” “medical services” “reproductive health care facility” ²³
Maryland	“Medical facility;” “health care facility,”
Maine	“Building;” “health service[s];”
Michigan	“health facility or agency”
Minnesota	“health care;” “facility”
Montana	“health care facility”
North Carolina	“private health care facility;” “health care facilities;” “health care services in the facility;” “health care services”
Nevada	“office of a physician, a health facility, a nonprofit health facility, a public health center, a medical facility or a facility for the dependent”
New Hampshire	“Reproductive health care facility” “Patient escort services”
New York	“health care services or religious worship;” “reproductive health services;” “place of religious worship;” “health care facility;” ²⁴ “religious services”
Oregon	“medical facility used in direct service to the public”
Washington	“health care facility”
Wisconsin	“medical facility”

These statutes overwhelmingly rely on ambiguous language that does not refer to abortion. Further, the California and New York laws include protections against interference in religious services as a means of balancing anti-abortion and pro-choice interests. In this way, the content of these statutes distinctly differs from other abortion policies that clearly correspond to a morality framework, such as provisions regulating public funding for abortion (Berkman and O'Connor 1993, 108).²⁵ This textual analysis underscores the theory that elites prioritize public

²³ Only the 2000 provision of Massachusetts's law that creates a buffer zone, Mass. Gen. Laws, ch. 266, §120E½(a), (b), explicitly refers to “reproductive health care facility.” The 1993 provision prohibiting obstruction and threat, Mass. Gen. Laws, ch. 266, §120E, refers only to “medical facility” and “medical services.”

²⁴ New York specifically defines “health care facility” as “a hospital, clinic, physician's office or other facility that provides reproductive health services, and includes the building or structure in which the facility is located” (New York Penal Law § 240.70 Criminal interference with health care services or religious worship in the second degree). It is the only clinic access laws to do so.

²⁵ The Guttmacher Institute (2018b) and Kaiser Foundation (2017) provide an overview of state laws regulating public funding for abortion.

safety and content neutrality in the clinic access law context rather than their own ideology and mass-level pressures.

Indeed, it appears that elites are not responding to state-level demand for abortion when enacting clinic access laws. Table 4 shows that the abortion rate **H(8)** variable did not significantly predict the enactment of clinic access laws. The relationship between the abortion rate variable and clinic access law dummy is in the expected direction (positive), and it fell just short of statistical significance ($p < 0.108$). However, when the anti-abortion interest group variable was separated into its component parts in Table 5, abortion rates became significantly positively correlated with the clinic access law dummy at the $p < 0.05$ level. These mixed results are suggestive of several mechanisms. First, it is possible that higher abortion rates signify a state's commitment to ensuring the availability of abortion services (Freilich and Pridemore 2007; Jacobsen and Royer 2011; Medoff 2003; Nice 1988). Consequently, it is unsurprising that clinic access laws are more likely to be enacted in states where abortion is already quite accessible. Second, higher abortion rates could indicate that the anti-abortion movement is weak or has failed to reach its goals in a particular state. As a result, the state government would face less grassroots opposition to the passage of an access law (Freilich and Pridemore 2007; Nice 1988). Third, past research has shown higher abortion rates are significantly positively correlated with rates of clinic bombings, harassment, and vandalism (Bartholomew 2012; Freilich and Pridemore 2007; Jacobsen and Royer 2011; Nice 1988). As abortion rates increase and clinic violence and harassment rise in turn, state political elites may feel compelled to produce clinic access laws in response. In this light, the result in Table 5 may also lend some credence to **H(5)**, which predicted that clinic violence and property attacks would be positively related to the probability of clinic access law enactment.

Importantly, the inconsistency of these results support **H(11)**, which asserts that clinic access laws are more likely to be redistributive policies than morality policies. The abortion rate is a mass-level variable that captures the demand for abortion and clinics' capacity to provide it. The lack of a significant correlation between this variable and the probability of clinic access law passage in Table 4 implies that state political elites are not necessarily responding to public abortion-related demands when enacting these laws.

State approaches to gender-based violence also do not predict clinic access law enactment: the correlation between the rape rate and clinic access law dummy fell in the expected positive direction but was insignificant. It was predicted that higher rates of rape would indicate a state culture that is reluctant to combat gender-based violence, leading to higher rates of clinic violence and harassment **H(7)**. These conditions could eventually spark a public safety risk that is significant enough to impel the enactment of an access law. However, it is probable that anti-abortion activists are simply unaware of state-level rates of gender-based violence, rendering them less likely to respond to these cultural cues.

Moreover, as Table 4 demonstrates, the presence of the FACE law is significantly negatively correlated with the likelihood of clinic access law enactment at the state level **H(9)**. The negative correlation coefficient was expected given that most access laws were enacted after 1994, the year that FACE became law. Despite its shortcomings, FACE created strong legal consequences for those convicted of clinic violence and harassment, which drove down clinic blockades and invasions in the years after its enactment (Cohen and Connon 2015, 209). Its passage led to the near demise of Operation Rescue, the anti-abortion group that propelled waves of clinic harassment and blockades throughout the late 1980s and early 1990s (Munson 2008, 89). Thousands of its members were arrested and fined under FACE, draining the group's

resources (Munson 2008, 89). Further, the law increased the possibilities for clinic staff to coordinate with federal law enforcement before, during, and after incidents of clinic violence and harassment (Cohen and Connon 217-28). Together, these outcomes likely reduced the need for states to enact their own clinic access laws in the post-FACE period.

Ultimately, the findings in Table 4 provide empirical evidence for the powerful influence of female legislators on the enactment of abortion clinic access laws, independent of ideological institutional control of state governments. Across the models in Tables 4 and 5, this variable was one of only two predictors that remained significant, offering strong evidence for **H(6)**. These results comport with the literature on state-level abortion policy and state politics as a whole, which generally asserts that women legislators are typically more liberal and pro-choice than male legislators (Berkman and O'Connor 1993; Norrander and Manzano 2011; Swers 1998). Further, women legislators are most influential in the context of symbolic abortion policies, which are typically less salient—and consequently, bear a lower level of political risk—than abortion policies that are framed as forms of social welfare (Berkman and O'Connor 1993, 108-9).

Indeed, clinic access laws are not simply symbolic. They directly affect women's access to reproductive health care, even if they do not regulate abortion itself or public funding for the procedure (Medoff 2012, 245). Nevertheless, as is the case with symbolic abortion policies, it is possible that only the most dedicated activists in the abortion policy sphere are affected by and cognizant of clinic access laws (Berkman and O'Connor 1993, 104). Further, clinic access laws are technically complex and produced outside of the morality policy framework. Therefore, they may not provoke especially heated pro-choice or anti-abortion fervor. The results of this study underline this argument: the relationships between the public anti-abortion attitudes, anti-

abortion interest group strength, abortion rates, and state mass political ideology variables and the clinic access law dummy all failed to reach statistical significance. Further, clinic access laws are not laden with the same polarizing arguments about sin and core values that are associated with other forms of morality-based abortion policies. Instead, they typically aim to protect public safety, and they often receive bipartisan support (Myers 1993; Perez-Pena 1999; Wilson 2013, 94-5). Together, these conditions perhaps provide the ideal environment for women legislators to support these laws. Anecdotal evidence bolsters this claim. Wilson (2013) remarks that the sponsor of Colorado's buffer zone bill, rookie Democratic state representative Diane DeGette, relied on this reasoning when she first decided to push the issue in the state house. Having been active in the pro-choice community before her election, she sought to provide the state's reproductive health clinics with support. After contacting several local clinics, DeGette discovered that clinic staff believed they needed stronger protections against clinic blockades, protests, and harassment. In turn, she took up the buffer zone bill because it had the potential to help clinics, and it was pro-choice legislation that "did not initially appear overly controversial" (Wilson 2013, 76). Thus, it seems that access law's relatively low levels of salience and technical complexity may decrease the political risk of advocating for them. These traits could reduce the potential for public and elite backlash against women state legislators who sponsor and vote for these laws.

Additionally, the significant relationship between the percent of female legislators and the clinic access dummy reinforce **H(11)**, which was the prediction that clinic access laws are not morality policies. Medoff (2012) and Medoff and Dennis (2011) argue that factors that capture institutional control of a state government are more likely to predict redistributive policies than morality policies. The percent of female legislators is an institutional rather than mass-level

factor, and it is one of only two significant predictors of access law enactment in this study. In the case of clinic access laws, it appears that women legislators are adhering to their own public safety concerns, ideology, and/or abortion attitudes rather than those of their constituents.

Thus far, the analyses discussed have focused on patterns in clinic access law enactment, demonstrating support for the hypotheses that clinic access laws are not morality policies **H(11)** whose enactment is significantly predicted by the passage of FACE **H(9)** and the percent of female members of a state's legislature **H(6)**. To test **H(10)**—the prediction that there would be a negative relationship between the reporter shield law dummy variable and the buffer zone law dummy—I conducted analyses on the subset of states with clinic access laws. The results of the event history analyses on this subset, reported in Table 7, tell a slightly different story than those run on all 50 states and DC.

Table 7. Determinants of buffer and bubble zone law enactment.²⁶

	Model 1
Anti-abortion attitudes	0.158 (0.235)
Anti-abortion interest groups	-0.064 (0.108)
Abortion rate	0.043 (0.071)
Mass state political ideology	-2.031 (4.078)
State political elite ideology	0.006 (0.0123)
Percent of female legislators	-0.057 (0.406)
FACE	11.884 (11.391)
Rape rate	-0.070 (0.110)
Reporter shield law	-2.321 (3.013)
Constant	183.066 (193.505)
<i>N</i>	672

Coefficients are listed with standard errors in parentheses. *** $p < 0.01$. ** $p < 0.05$. * $p < 0.10$.

In the analyses in Table 7, the dependent variable was the buffer zone law dummy, which was coded as “1” in the year that a state enacted a buffer zone law, if at all. The violence variable was dropped from this analysis: the infrequency of incidents of clinic violence in this subset

²⁶ The model included a cubic polynomial of the year count, but does not display the results. The year count, squared year count, and cubed year count did not reach statistical significance.

prevented the statistical software from completing its analysis of the model. I used a rare events logistic regression (“relogit”) rather than a regular logistic regression to account for the fact that the “0”s in the buffer zone law dummy far outnumbered the “1”s (Tomz, King, and Zeng 1999; Tomz, King, and Zeng 2003). I coded the dummy as “1” for only four out of the 672 observations since only four buffer zone laws have been enacted. The reporter shield law variable was added to the analyses to account for state approaches to free speech.

As shown in Table 7, none of the variables in this model reached statistical significance. Importantly, the results provide little support for **H(10)**. While the relationship between the reporter shield law and buffer zone dummy fell in the expected negative direction, the correlation was not significant. This finding indicates that a state’s historical approach to free speech does not necessarily influence its propensity towards enacting buffer zone laws. However, the lack of a significant relationship between these variables may stem from the surrogate measure used to operationalize a state’s approach to free speech. Using other forms of speech regulation to create an index that could more accurately gauge this variable may lead to different results.

Further, the general absence of statistically significant relationships in Table 7 may indicate that buffer zone laws are even further removed from the conventional abortion politics context than other forms of clinic access laws. Anecdotal evidence indicates that the contention surrounding these laws tends to focus much more heavily on their constitutionality than their capacity to facilitate abortion access (Wilson 2013; Johnson 2014; Stevens 2014). In fact, three of the four buffer zone laws in existence have been legally challenged on the grounds that they violate anti-abortion protesters’ free speech rights (*Hill; McCullen; Solomon* 2017).²⁷

²⁷ Anti-abortion activists challenged New Hampshire’s law in the US District Court in Concord, New Hampshire, in 2016 (*Reddy et al. v. Foster et al.* Civil No. 14-cv- 299-JL). The District Court denied their request for a hearing. The activists then appealed the case to the US Court of Appeals for the First Circuit in Boston, Massachusetts (*Reddy et al. v. Foster et al.* 845 F.3d 493, 2017; Solomon 2017). The court found in favor of the respondents. It

Consequently, it is quite possible that lawmakers must dedicate significant time and effort to ensure that these laws are constitutional, detracting public, media, and elite attention from their effects on abortion access.

Finally, there was not a statistically significant relationship between the percent of female legislators and the likelihood of clinic access law enactment. Still, there is evidence to suggest that women legislators play a substantial role in the passing of buffer zone statutes: Democratic women in fact introduced and were the primary sponsors of the original bills creating all four of these laws.²⁸ Thus, in the context of buffer zone laws, it may be that female legislators make the strongest impact through issue advocacy and agenda setting, prioritizing and introducing bills that mainly affect women and their family planning choices. These results fall in line with previous literature on women's substantive representation in state legislatures and other public offices, which has shown that female legislators' influence is strongest in the most "formative" stages of policymaking (Reingold 2006, 247).

Chapter 5: Conclusions, Limitations, and Implications

This study demonstrates that abortion clinic access laws should be classified as redistributive rather than morality policies. The likelihood of their enactment is not predicted by mass-level factors (anti-abortion attitudes, anti-abortion interest group strength, state mass political ideology, and abortion rates). It is also not predicted by state political elite ideology or states' tolerance for gender-based violence. One of the institutional-level variables in the study,

asserted that the plaintiffs had no standing to sue since New Hampshire's law had not yet gone into effect, and no clinic in the state had put up signage demarcating the area of a buffer zone (Solomon 2017).

²⁸ Colorado state representative Diane DeGette was the first legislator to push for a buffer zone bill in her state. She later asked Democratic state senator Mike Feeley to co-sponsor the bill in the senate (Wilson 2013, 76). Massachusetts state senator Susan Fargo introduced legislation creating the first version of the state's buffer zone statute in 2000 ("SJC finds buffer zones legal," 2000). In Montana, state representative Robyn Driscoll introduced the state's buffer zone bill in 2005 (Montana HB 324 2005). Finally, state senator Donna Soucy introduced New Hampshire's buffer zone bill in 2014 (New Hampshire SB319 2014).

the percent of female state legislators, did significantly increase the likelihood of access law passage, thereby bolstering the theory that these laws are best classified as redistributive policies. Additionally, the enactment of FACE in 1994 was significantly negatively associated with access law enactment. Buffer zone laws seem to be positioned even further outside the morality framework: their enactment was not predicted by mass-level or institutional factors or a state's historical approach to free speech

In general, the debate surrounding clinic access laws touches on issues outside of abortion and reproductive health care, broaching topics such as speech rights, assembly rights, and public safety. These patterns engender pressures that cut across socially constructed and temporally specific anti-abortion/pro-choice and liberal/conservative dichotomies. In turn, these characteristics decrease the “technical simplicity” of clinic access laws as well as the ability of those who are not proximate stakeholders in the policymaking process (i.e., committed activists, political elites, and law enforcement entities) to form an opinion on and mobilize around them (Kreitzer 2015a, 61).

This study is not without limitations. Most significantly, the statistical models only included a measure of clinic violence and property damage as an independent variable, leaving out data on the thousands of incidents of clinic harassment that have occurred since *Roe* (NAF 2017). Future work on clinic access laws should seek to understand the exact relationship between harassment, blockades, protests, and picketing at the state level in addition to clinic violence and property damage. Second, conducting case studies that trace the process of clinic access law enactment would likely provide helpful insight to the legislative history of these laws. In particular, utilizing qualitative methods would help to illuminate whether there is truly a

connection between a state's historical approach to free speech and its decision to enact—or not enact—a buffer zone law.

Nevertheless, this study offers a useful point of departure for the future study of clinic access laws, which have received very little social scientific attention. It also identifies an area of public policy where women legislators have made, and can continue to make, a significant impact. In this way, it helps to fill the gaps in the literature on if, when, and how women in public office can engage in substantive representation of their female constituents. This study usefully clarifies the literature on pro-abortion rights policies, which has struggled to identify the mechanisms through which these policies are generated (Kreitzer 2015a, 91). Ultimately, this paper offers a starting point for reimagining the conventional understanding of contemporary abortion politics in the United States. Since *Roe*, the debate over abortion has been increasingly portrayed as a zero-sum battle between the conservative Christian right and the liberal pro-choice left. Narrowing the empirical focus to a specific type or set of abortion-related policies problematizes this depiction.

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Appendix A: Clinic Access Law Contents, Location and Year of Enactment, 1981-2014

State	Contents	Location in state code	Year of enactment
California	Prohibits threats and property damage	Penal Code § 423-423.6	2001
California	Prohibits obstruction	Penal Code § 602.11	1993
California	Prohibits arson and use of explosives at clinics	Penal Code § 11413	2005
California	Prohibits blockades	Civil Code § 3427-3427.2	1995
California	Prohibits butyric acid attacks on structures	Penal Code § 584.4	1993
Colorado	Creates a buffer/bubble zone: within 100 feet of clinics, protestors cannot approach within 8 feet of clinic staff, patients and escorts	Kansas Statutes. Crimes and Punishments § 21-3721	1993
DC	Prohibits obstruction, threat, damage, and excessive noise	D.C. Code Ann. § 22-1314.01-1314.02	1996
Kansas	Prohibits obstruction	Kansas Code § 21-3721	1992
Massachusetts	Prohibits obstruction and threats	General Laws Ch. 266, section 120E	1993
Massachusetts	Currently creates 25-foot buffer zone around clinics (2000 version of law created an 18-foot bubble zone in which protestors could not approach within 6 feet of clinic staff, patients, and escorts; 2007 version created 35-foot buffer zone)	General Laws Ch. 266, section 120E1/2	2000
Maine	Prohibits obstruction, telephone harassment, excessive noise, and offensive odor	Me. Rev. Stat. Ann. tit. 5, § 4684-B	1995

Maryland	Prohibits obstruction	Maryland Code. Criminal Law § 10-204	2002
Michigan	Prohibits threat	Compiled Laws. Public Health Code § 333.20198	1998
Minnesota	Prohibits obstruction	Minnesota Statutes. Criminal Code § 609.7495	1993
Montana	Prohibits obstruction and creates 8-foot bubble zones within 35-foot buffer zones around clinics	Montana Code Annotated § 45-8-110	2005
Nevada	Prohibits obstruction	Nev. Rev. Stat. Ann. § 449.760	1991
New Hampshire	Creates a 25-foot buffer zone around clinics	N.H. Rev. Stat. Ann § 132:38	2014
New York	Prohibits obstruction, threat, and property damage,	N.Y. Penal Law §§ 240.70 to .71	1999
North Carolina	Prohibits having a weapon on medical facility grounds	N.C. Gen. Stat. Ann. §14-277.2	1981
North Carolina	Prohibits obstruction	N.C. Gen. Stat. Ann. §14-277.4	1993
Oregon	Prohibits obstruction and damage	Revised Statutes- Crimes and Punishments §164.365	1991
Washington	Prohibits obstruction, threat, excessive noise, trespass, telephone harassment, and property damage	Revised Code Washington Criminal Code 9A.50.020 § 9A.50.070	1993
Wisconsin	Prohibits trespassing	Wisconsin Statutes § 943.145	1985

This table was compiled using the content of clinic access laws; the Guttmacher Institute’s webpage, “Protecting Access to Clinics;” NARAL’s webpage, “State Governments;” and Bartholomew’s (2012) appendices (122-148).

Appendix B: States with both Reporter Shield Laws and Clinic Access Laws and Year of Reporter Shield Law Enactment

State	Year of Reporter Shield Law Enactment
California	1985
Colorado	1991
Kansas	2010
Maine	2007
Maryland	2014
Minnesota	1973
Montana	1943
Nevada	1971
New York	1970
North Carolina	1999
Oregon	1973
Washington	2007
Wisconsin	2009